UPTOWN
ALLERGY & ASTHMA

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

DOB: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

HM #: _____ WK #: _____ Cell #: _____

Email: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

Race: ☐ Caucasian ☐ American Indian ☐ African American ☐ Asian ☐ Pacific Islander ☐ Other

Ethnicity: Hispanic / Non-Hispanic / Other

Employer: _____ Occupation: _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ DOB: _____

Relationship to Patient: _____ Policy Holder's SS#: _____

Policy Holder Employer: _____

Primary Insurance Company: _____

Primary Insurance ID #: _____ Group #: _____

Secondary Insurance Company: _____

Secondary Insurance ID #: _____ Group #: _____

CARE TEAM

Primary Care Physician: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone #: _____

PHARMACY INFORMATION

Name: _____ Address: _____ Phone: _____

How were you referred? ☐ ***Website*** ☐ ***Physician:*** _____ ☐ ***Friend:*** _____

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2620 Jena St, New Orleans, LA 70115
Phone: 504-605-5351 Fax: 877-637-9467
info@uptownallergyasthma.com
www.uptownallergyasthma.com

HEALTH INFORMATION SHEET

PAST MEDICAL HISTORY – Please list ALL past medical problems:

1. _____
2. _____
3. _____
4. _____

PAST SURGICAL HISTORY – Please list all past surgeries and the date that they were performed:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

ALLERGY HISTORY – Are you allergic to any food, medicine, chemical, latex, insects, and/or other?

YES ☐ NO ☐ If yes, please list: _____

_____

FAMILY HISTORY – Please list medical problems experienced by patient's family members: (Include allergy/asthma/eczema/immune problems)

Mother's Side: _____

Father's Side: _____

SOCIAL HISTORY– Please answer the following questions:

Do you have pets? NO ☐ YES ☐ If yes, what type and how many? _____

Do you currently smoke or have you smoked in the past? NO ☐ YES ☐ If yes, how long? _____

Do you consume alcohol? NO ☐ YES ☐ If yes, how many drinks per week? _____

Do you exercise? NO ☐ YES ☐ If yes, what type of exercise? _____ How often? _____

Are you exposed to mold/fumes/strong odors/chemicals? NO ☐ YES ☐ If yes, where/what? _____

_____

CURRENT MEDICATION– Please list current medicines including dose and directions. (Over the Counter, prescription medicine and herbal remedies)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

[For Office Use Only]

Reviewed By MD_____ **Date:** _____

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CONSENT TO E-SIGNATURES

I agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

Signature: _____ Date: _____

RELEASE OF INFORMATION

I authorize the release of any information necessary to process insurance claims. I also authorize payment of benefits to Uptown Allergy & Asthma LLC. I authorize your office to leave messages on my telephone voicemail for numbers listed above.

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

All co-payments are due at time of service. I understand that certain charges may not be covered by my insurance and I am responsible for all charges incurred. If a referral is required by my health insurance plan, I understand that the referral must be valid and completed with the provider name. I understand that I will be held responsible for the cost of services provided if I do not present any insurance.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I understand that I have a right to review Uptown Allergy & Asthma's HIPAA Notice of Privacy Practices.

Patient Name (Type or Print) (or Parent if under 18) _____
Signature_____
Date _____

Minor Patients Only

Mother's Name: _____ *Preferred Phone:* _____
Father's Name: _____ *Preferred Phone:* _____
If you would like to designate another party to accompany patient to office visit(s), allergy injection(s), procedure(s), etc., please complete the section below:
Name: _____ *Relationship:* _____ *Phone:* _____
Name: _____ *Relationship:* _____ *Phone:* _____
_____ *I consent and authorize the above parties to also consent to and authorize evaluation and treatment for my child when I'm not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures for my child. The duration of this consent is indefinite and continues until revoked in writing (please initial).*
_____ *I am authorized to consent to medical treatment for this minor child (please initial).*

_____ _____
Patient Name *Date*

_____ _____
Parent/Guardian *Date*

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GENERAL CONSENT FOR CARE AND TREATMENT CONSENT TO THE PATIENT

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

_____ _____
Printed Name and Signature of Witness Employee Job Title

EMAIL CONSENT

I grant consent for Uptown Allergy & Asthma's staff to correspond with me via email for the purpose of scheduling appointments or conveying general information about my treatment or the treatment of my child. I understand that email is not a secure form of communication and that confidentiality of any emailed information cannot be ensured.

Patient Name (Type or Print) (or Parent if under 18) _____

Signature_____

Date _____

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TELEMEDICINE INFORMED CONSENT

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with Uptown Allergy & Asthma.

2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
    a. Details of your medical history, examinations, imaging and past tests will be discussed with members of the Uptown Allergy & Asthma team through the use of interactive video, audio, and telecommunication technology.
    b. A physical examination may take place

3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding access to medical information and copies of your medical records apply to this telemedicine consultation. Please note telecommunications are not recorded or stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with this telemedicine consultation, and all existing confidentiality protections under federal and Louisiana state law apply to information disclosed during this telemedicine consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **RISKS, CONSEQUENCES & BENEFITS:** You understand all the potential risks, consequences, and benefits of telemedicine. You have had the opportunity to ask questions and the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information presented above.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to a telemedicine consultation.

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Printed Name of Patient or Personal Representative | Relationship to Patient

_____ _____
Printed Name and Signature of Witness | Employee Job Title