



**WELLINGTON OFFICE**  
12977 Southern Blvd - Suite 200  
Loxahatchee, FL 33470

**BOCA RATON OFFICE**  
9960 Central Park Blvd, N - Suite 300  
Boca Raton, FL 33428

**Rabia Q. Chaudhry, MD, FAAAAI**  
Phone/Text (561) 855-1999 Fax (561) 898-1093  
[DrChaudhry@SouthFloridaFoodAllergyCenter.com](mailto:DrChaudhry@SouthFloridaFoodAllergyCenter.com)

### PATIENT REGISTRATION

#### Patient Information:

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Sex: \_\_\_ Age: \_\_\_ Birthdate \_\_\_\_\_ Name of person who drove patient here: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

#### Emergency Contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_ Guardian: Y/N

#### Medical History:

Primary Physician's Name \_\_\_\_\_

Address: \_\_\_\_\_ Office Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Address (Cross Streets) \_\_\_\_\_ Number \_\_\_\_\_

#### Insurance Information:

Primary Insurer Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Do you need a referral? Y/N

Who can we thank for telling you about us? \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_



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Medications

Please list all medications you/your child are currently taking:

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ 1 2 3 Times Daily  
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ 1 2 3 Times Daily  
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ 1 2 3 Times Daily  
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ 1 2 3 Times Daily  
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ 1 2 3 Times Daily

Known Allergies

Please list all known allergies (environmental, drug, food) as well as the type of reaction and level of severity:

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_ Severity: Mild Moderate Severe  
Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_ Severity: Mild Moderate Severe  
Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_ Severity: Mild Moderate Severe  
Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_ Severity: Mild Moderate Severe  
Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_ Severity: Mild Moderate Severe

Continue on back if needed

Surgeries

\_\_\_\_\_ Year: \_\_\_\_\_ Year:  
\_\_\_\_\_ Year: \_\_\_\_\_ Year:

Chronic Medical Issues

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pediatric Patients

Full Term : Yes No Any issues at birth: \_\_\_\_\_  
Formula or Breast milk or Both

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Social History

Smoking Status for adult patients:

- Cigarette/Cigar Smoker    Never    Occasional    Weekly    Daily
- Chewing Tobacco            Never    Occasional    Weekly    Daily

If applicable:

When did you start smoking? \_\_\_\_\_ Number of packs per  
day: \_\_\_\_\_

When did you quit smoking? Congratulations! \_\_\_\_\_ Total number of years smoking: \_\_\_\_\_

Family History

Please list any immediate family history of illness or disease:

Disease/Illness: _____	Relation: _____	Deceased? Yes No
Disease/Illness: _____	Relation: _____	Deceased? Yes No
Disease/Illness: _____	Relation: _____	Deceased? Yes No
Disease/Illness: _____	Relation: _____	Deceased? Yes No
Disease/Illness: _____	Relation: _____	Deceased? Yes No
Disease/Illness: _____	Relation: _____	Deceased? Yes No

Do any IMMEDIATE family members have (circle all that apply):

ASTHMA            FOOD ALLERGIES            IMMUNE DISEASE            AUTOIMMUNE DISORDERS

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Environmental Survey

1. Do you live in a house, apartment/duplex, or condominium/townhouse? \_\_\_\_\_
2. How long have you lived in your home? \_\_\_\_\_
3. Approximately how old is your home? \_\_\_\_\_
4. Do you live in a city, suburb, or rural area? \_\_\_\_\_
5. Do you have air conditioning? Yes or No Window unit or Central air
6. Type of heating: Hot air Steam/radiator Electric hot water
7. Do you have:
  - Wood/coal stove or fireplace
  - Humidifier
  - Dehumidifier
  - Air cleaner
8. Pets? Yes or No How many? \_\_\_\_\_ Do they sleep in patient's room? Yes or No  
Cats Dogs Birds Other \_\_\_\_\_
9. Are there any tobacco smokers in your home? Yes or No. Please advise them to quit!
10. What type of pillows do you or your child use?  
Cotton Down Poly fiber Memory Foam Other:
11. What type of floor covering is there in the bedroom? \_\_\_\_\_
12. Do you have water leaks, mold contamination? Yes or No
13. Is your home/apartment excessively humid? Yes or No
14. Do you/your child experience runny nose or sneezing in response to strong odor? Yes or No
15. Do you/your child experience runny nose or sneezing in response to exercise? Yes or No

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1. What symptoms are you/your child experiencing?

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2. How often do you/your child experience these symptoms? \_\_\_\_\_

3. Do you/your child have any of these symptoms?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cough                | <input type="checkbox"/> Ear infections    | <input type="checkbox"/> Poor sense of smell             |
| <input type="checkbox"/> Runny nose           | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Hives/swelling                  |
| <input type="checkbox"/> Nasal polyps         | <input type="checkbox"/> Chest tightness   | <input type="checkbox"/> Fatigue                         |
| <input type="checkbox"/> Eczema               | <input type="checkbox"/> Itchy/watery eyes | <input type="checkbox"/> Blocked ears                    |
| <input type="checkbox"/> Wheezing             | <input type="checkbox"/> Sinus infections  | <input type="checkbox"/> Phlegm/sputum<br>(Color: _____) |
| <input type="checkbox"/> Nasal congestion     | <input type="checkbox"/> Sneezing          | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Shortness of breathe | <input type="checkbox"/> Snoring           |  |
| <input type="checkbox"/> Itchy nose           | <input type="checkbox"/> Postnasal drip    |  |

4. Which of the following seems to bother or trigger/cause the above symptoms?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Grass          | <input type="checkbox"/> Smoke           | <input type="checkbox"/> Insect bites/stings<br>Describe<br>reaction: _____ |
| <input type="checkbox"/> Cats           | <input type="checkbox"/> Humidity        | _____   |
| <input type="checkbox"/> Cosmetics      | <input type="checkbox"/> Basements       | <input type="checkbox"/> Foods List foods and<br>reactions: _____           |
| <input type="checkbox"/> Drafts         | <input type="checkbox"/> Other animals   | _____   |
| <input type="checkbox"/> Nervousness    | <input type="checkbox"/> Insecticides    | _____   |
| <input type="checkbox"/> Hay            | <input type="checkbox"/> Pollution       | <input type="checkbox"/> Other. List sources and<br>reaction: _____         |
| <input type="checkbox"/> Dogs           | <input type="checkbox"/> Weather changes | _____   |
| <input type="checkbox"/> Aerosol sprays | <input type="checkbox"/> Leaves          | _____   |
| <input type="checkbox"/> House dust     | <input type="checkbox"/> Latex (rubber)  | _____   |
| <input type="checkbox"/> Cold air       | <input type="checkbox"/> Odors           | _____   |
| <input type="checkbox"/> Mold & Mildew  | <input type="checkbox"/> Exercise        | _____   |
| <input type="checkbox"/> Horses         |  | _____   |
| <input type="checkbox"/> Perfumes       |  | _____   |

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5. When are the symptoms the worst?

- Year round                       Summer                       Winter  
 Spring                               Fall

6. Are symptoms better away from home? Yes No

If yes, when? \_\_\_\_\_

7. Have you/your child ever had an allergy test or blood test?  Yes  No

If yes, when? \_\_\_\_\_

8. Have you/your child ever had allergy injections?  Yes  No

If yes, when? \_\_\_\_\_

9. Have you/your child ever used cortisone, prednisone, methylprednisolone, etc. drugs? Yes No

10. Are you/your child on any allergy medications?  Yes  No

What medications? \_\_\_\_\_

How much? \_\_\_\_\_

How long? \_\_\_\_\_ Last Used \_\_\_\_\_

11. Are you sick of answering questions yet? Yes No ☺

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**HIPAA Acknowledgement and Consent Form**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up care among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your notice of privacy practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such notice of privacy practices prior to signing this consent, and acknowledge that I have studied the privacy practices prior to signing this, consent and acknowledge that I have studied the privacy practices. I understand that this organization has a right to change its notice of privacy practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the notices of privacy practices.

I understand that I may request in writing that this organization restrict how private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient (if minor patient): \_\_\_\_\_



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### **Financial Policy**

In order to accommodate the needs and requests of as many patients as possible, South Florida Food Allergy Center is contracted with numerous insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Providing quality medical care for our patients is our primary concern.

#### **Self-Pay Patients**

If you are a self-pay patient, you are 100% responsible for all charges associated with your treatment. You will be expected to make payment in full at the time of service.

#### **Outstanding Obligations**

You may be required to settle all outstanding financial obligations before new appointments are scheduled or office services are performed. South Florida Food Allergy Center reserves the right to discharge a patient from the practice for non-payment of services.

#### **Forms Completion Fee**

South Florida Food Allergy Center will complete school forms presented at the time of an office visit at no charge. There will be a \$5.00 fee to process any school form not presented during an office visit. Form fees are due at the time of pick up. Insurance companies will not be billed for those services.

Our continued participation in your health plan depends upon everyone fulfilling his/her obligation in accordance with our contracts. As a service to our patients, we obtain a description of benefits from your insurance. This office is not responsible for incorrect benefit information given to us by your insurance carrier. A description of benefits is not a guarantee of coverage and cannot be relied upon as such. In the event of non-payment by your insurance company, the charges incurred will be your responsibility. Patients are responsible for all deductibles, co-payments, coinsurance, and non-covered charges. Payment is due at the time services are rendered. We accept Visa, MasterCard, Discover, American Express, Personal Checks, and Cash for your convenience. If you want to verify insurance benefits quoted yourself, please contact your insurance company.

Patient Consent: I hereby give consent for such medical treatment for myself or I am duly authorized by the patient and his/her general agent to consent for such treatment.

Assignment of Benefits: I hereby authorize payment for medical benefits directly to South Florida Food Allergy Center for services rendered.

Release of Information: I hereby authorize the release of an medical information necessary to process any insurance claims.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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Authorization to Release Medical Information

Release From:

Release to:

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Records to be release:

- Health Records
- Allergy Skin Tests
- Pulmonary Function Tests
- Other \_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be

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NAME PRINT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_