SOUTH FLORIDA
FOOD ALLERGY CENTER

WELLINGTON OFFICE
12983 Southern Blvd - Suite 101
Loxahatchee, FL 33470

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

Rabia Q. Chaudhry, MD, FACAAI
Phone/Text (561) 855-1999 Fax (561) 898-1093
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 Insured's Name:_____ Birth Date:_____

Insurance Name:_____ Member ID:_____**Do you need a referral?** Y/N

Who can we thank for telling you about us? _____

South Florida Food Allergy Center – Remember you can call, text or fax us anytime at 561-855-1999
www.SouthFloridaFoodAllergyCenter.com

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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. Does patient 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. Does patient experience runny nose or sneezing in response to strong odor? Yes or No
15. Does patient experience runny nose or sneezing in response to exercise? Yes or No

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1. What symptoms is patient experiencing?

_____

_____

2. How often does patient experience these symptoms?_____

3. Does patient have any of these symptoms?

- ☐ Cough
- ☐ Runny nose
- ☐ Nasal polyps
- ☐ Eczema
- ☐ Wheezing
- ☐ Nasal congestion
- ☐ Shortness of breath
- ☐ Itchy nose
- ☐ Ear infections
- ☐ Headaches
- ☐ Chest tightness
- ☐ Itchy/watery eyes
- ☐ Sinus infections
- ☐ Sneezing
- ☐ Snoring
- ☐ Postnasal drip
- ☐ Poor sense of smell
- ☐ Hives/swelling
- ☐ Fatigue
- ☐ Blocked ears
- ☐ Phlegm/sputum (Color:_____)
- ☐ Other_____

4. Which of the following seems to bother or trigger/cause the above symptoms? It's OK not to know!

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

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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. Has patient ever had an allergy test or blood test? Yes☐ ☐No

If yes, when? _____

8. Has patient ever had allergy injections? Yes☐ ☐No

If yes, when? _____

9. Has patient ever used cortisone, prednisone, methylprednisolone, etc. drugs? Yes No

10. Is patient 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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REVIEW OF SYSTEMS

Please indicate below your history of or current problems by circling YES. If you have never encountered a problem with any of the symptoms below, indicate such with a circle around NO.

General

YES NO Weight Gain
YES NO Weight Loss
YES NO Fever
YES NO Chills
YES NO Problems sleeping

Head, Eyes, Ears, Nose & Throat

YES NO Change in vision
YES NO Ear infections/drainage
YES NO Sinus infections
YES NO Problems swallowing
YES NO Glaucoma
YES NO Cataracts
YES NO Impaired hearing

Cardiovascular

YES NO Chest pain
YES NO Shortness of breath, active/lying
YES NO Heart murmur
YES NO Palpitations
YES NO Fainting

Pulmonary

YES NO Cough
YES NO Shortness of Breath
YES NO Sputum production
YES NO Emphysema/COPD
YES NO Asthma
YES NO Sleeping during the day
YES NO Snoring

Gastrointestinal

YES NO Heartburn
YES NO Change in appetite
YES NO Change in bowel habits
YES NO Black, tarry stool
YES NO Rectal Bleeding

Genitourinary

YES NO Pain while urinating
YES NO Burning while urinating
YES NO Blood in urine
YES NO Cataracts

Musculoskeletal

YES NO Arthritis
YES NO Muscle weakness
YES NO Frequent fractures
YES NO Osteoporosis
YES NO Joint stiffness

Neurological

YES NO Strokes
YES NO Seizures
YES NO Depression

Psychiatric

YES NO Depression
YES NO Anxiety
YES NO Other diagnoses

Endocrine

YES NO Hypothyroidism
YES NO Hyperthyroidism
YES NO Diabetes
___ Insulin
___ Other medications

Skin

YES NO Rashes
YES NO Jaundice
YES NO Skin cancer
Type:
_____

Other:

_____
_____
_____
_____
_____
_____
_____
_____

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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 abounded 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 out 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 any medical information necessary to process any insurance claims.

Patient Signature:_____ Date:_____

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Authorization to Release Medical Information

Release From:	Release to:
_____	_____
_____	_____
_____	_____
_____	_____

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

South Florida Food Allergy Center – Remember you can call, text or fax us anytime at 561-855-1999.

NAME PRINT:_____

SIGNATURE:_____ DATE:_____