Regina D. Wells, MD
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Call Today! (281)452-3300
Visit Us Online: www.wellsallergy.com

Wells Allergy & Asthma

Welcome

PATIENT INFORMATION

Patient Name (First, Middle, Last):

____

Date of Birth: ______/______/________ **Male / Female**

Home Address: _____________________________

City: _____________ State: _____ Zip: _________

SS#____________/______/_____________

Home /Cell Phone: (______) _______-_________

Work Phone: (____) ________-__________

Email: ______________________________

Pharmacy Name/Telephone: __________________________

____

Race: ☐ Black/African American ☐ White/Caucasian
☐Hispanic ☐Asian ☐ Other Race ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

☐ Refuse to Report

Language: ☐ English ☐ Indian ☐ Spanish ☐ Russian

Emergency Contact:

Name _______________________________________

Relationship: _________________________________

Phone: (_____) ______-_________

Responsible Party: (Primary Insurance Holder)

Name (First, Middle, Last):

____

Date of Birth:______/______/___________

Home Address: __________________________________

City: ____________________ State: _______ Zip: _________

Home Phone: (_____) ________-______________

Work Phone: (______) _______- ______________

Employer: ____

Name of Primary Insurance & Contact Information:

____

____

ID/Subscriber#: ____________________________________

Group#: ____

SS#: ____

Relationship: _______________________________________

Phone # for Providers: _______________________________

Secondary Insurance Name & Contact Information:

____

____

ID or Subscriber#:___________________________________

Group #:____

Phone # for Providers: _______________________________

Primary Care/Pediatrician Information:

____

Phone: (____) _______-____________

Fax: (___) _______-______________

Has a member of your family been here before? **Yes** **No**

If yes, patient name: ___________________

Relationship: _________________________

How were you referred to Wells Allergy Associates?

☐Dr. _____________________________ ☐ Friend

☐Yellow Pages ☐Newspaper (name): ______________
Mailing: ☐Ad ☐Postcard ☐Brochure ☐Newsletter
☐Insurance Company: _____________________

☐Other: _________________

HAVE YOU VISITED OUR WEBSITE AT www.wellsallergy.com? Yes No

Assignment of Benefits: I hereby authorize payments to any physician of Wells Allergy Associates who has treated my dependents or me for medical services rendered. I understand that I am financially responsible for all services not covered by my insurance company.* I also understand that if I do not give a minimum of 48 hours notice for cancellation of any procedure appointments, I will be billed a $50 cancellation fee that is not covered by my insurance and must be paid prior to any visits or procedures.
***We make every effort to contact your insurance company and verify benefits. However, verification of insurance benefits is not a guarantee of payment until claims are submitted and the insurance company reviews all records. If your insurance company denies payment or services are not covered, you become financially responsible for services. Please be aware that if you participate in an HMO and need a referral for this visit or any other services, IT IS YOUR RESPONSIBILITY TO MAKE SURE WE HAVE THE REFERRAL IN OUR OFFICE BEFORE THE VISIT. The office cannot be responsible for obtaining referrals.**

Signature: ____ **Date:** _________________

 Patient Name:

MEDICAL HISTORY (Circle "Yes" or "No")

Drug Allergy **Yes** **No** Food Allergy **Yes** **No** Insect Allergy **Yes** **No** Contact Allergies **Yes** **No**

If YES please list: ____

Up to date on vaccinations? **Yes** **No** Received Seasonal Flu vaccine this season? **Yes** **No**

Are you HIV/AIDS positive? **Yes** **No** **If YES to Seasonal Flu, what date (mm/yr):**________

HELPFUL ALLERGY/ASTHMA MEDICINES (please list):______________________________

UNHELPFUL ALLERGY/ASTHMA MEDICINES (please list):____________________________

List any surgeries:____

SOCIAL HISTORY

Occupation:______________________ School? **Yes** **No** Daycare? **Yes** **No**

Does alcohol cause/worsen allergy symptoms? **Yes** **No**

Secondary tobacco exposure? **Yes** **No** Personal tobacco use? **Yes** **No**

If YES, for Personal Tobacco USE:_________**Packs per day** **How long?** _______________**(Yrs)** Thinking about quitting? **Yes** **No**

If YES to Thinking About Quitting, answer the following:

Have you ever tried to, or felt the need to, Cut down on your smoking? **Yes** **No**

Do you ever get Annoyed when people tell you to quit smoking? **Yes** **No**

Do you ever feel Guilty about smoking? **Yes** **No**

Do you ever smoke within one-half hour of waking up (Eye opener)? **Yes** **No**

Pets (Circle what applies): **None** **Cats** **Dogs** **Other:**______________________

Does your pet stay? **Inside** **Outside** **Both** Does your pet sleep in **your** bedroom? **Yes** **No**

Increased allergy symptoms around animals? **Yes** **No**

For Child (under 8yrs of age): Full Term? **Yes** **No** Premature: born at ____ weeks Birth Weight: _________lbs

Failure to Thrive or other medical concerns prior to 8 years of age:__________________________

For Women: Last menstrual period:____/______/______ Think you're pregnant? **Yes** **No** Currently pregnant? **Yes** **No**

ENVIRONMENTAL HISTORY

Do you use allergy dust mite protectors on: **Pillows** **Mattress** **Both** **Neither**

Residence: Age of home? ______ Do you have evidence of water damage in your home? **Yes** **No**

(Circle what applies)

Heating/Cooling: **Central air/Heat** **Window units** **Ceiling fan** **Fireplace** **Stove warmers**

Bedroom Flooring: **Carpet?** **Yes** **No** **If NO, Rugs used?** **Yes** **No**

Bedroom Furniture: **Mattress** **Waterbed** **Down Bedding** **Stuffed toys**

Bedroom Window Coverings: **Yes** **No**

FAMILY HISTORY (Circle "Yes" or "No", if "yes" please list relative)

Allergies (Pollen/Food)	**Yes**	**No**	**Relative:**__________	Angioedema	**Yes**	**No**	**Relative:**__________
Asthma	**Yes**	**No**	**Relative:**__________	Emphysema/COPD	**Yes**	**No**	**Relative:**__________
Eczema/Rash	**Yes**	**No**	**Relative:**__________	Drug Allergies	**Yes**	**No**	**Relative:**__________
Urticaria (hives)	**Yes**	**No**	**Relative:**__________	Hypertension	**Yes**	**No**	**Relative:**__________
Sinus problems	**Yes**	**No**	**Relative:**__________	Diabetes	**Yes**	**No**	**Relative:**__________

Other diseases that run in the family: ____

REVIEW OF SYSTEMS (Circle if PATIENT has had symptoms in the past 3 MONTHS)

General:	**Fever**	**Chills**	**Night Sweats**	**Weight Loss**	**Weight gain**
Ear, Eyes, Nose, Throat:	**Drainage**	**Foul Breath**	**Teeth Pain**	**Hoarseness**	
Heart:	**Pain/Pressure**	**Palpitations**	**Murmur**	**Irregular rhythm**	
Intestines:	**Heartburn**	**Bleeding**			
Skin:	**Moles**	**Warts**	**Rosacea**	**Nail fungus**	
Extremities:	**Swollen joints**	**Painful joints**	**Fractures**	**Muscle pain**	**Arthritis**
Urinary:	**Pain/burning**	**Discharge**	**Yeast infection**	**Increased urination**	**Difficulty urinating**
Hematology:	**Easy bruising**	**Swollen glands**	**Blood clots**	**Miscarriages**	**Anemia**
Endocrine:	**Excessive thirst**	**Heat intolerance**	**Cold intolerance**	**Thyroid concerns**	
Neurological:	**Headache**	**Fainting**	**Seizures**	**Learning difficulty**	**Developmental concerns**
Psychological:	**Stress**	**Anxiety**	**Depression**	**Loss of sleep**	

POLICIES

Federal Tax ID: 26-4706072

Welcome and thank you for choosing Wells Allergy Associates for your medical care.

We are committed to providing you with quality medical care, our professional fees have been determined through careful consideration, and we believe these fees are reasonable and reflect other area physician's charges. We are pleased to discuss with you any questions you may have concerning your bill. Providing quality care is our primary concern.

Regarding Insurance

Indemnity and Private Insurance Policies: Wells Allergy Associates will file claims directly with your insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee your insurance will pay for services. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

Contracted Managed Care Plans (HMO, PPO, POS, EPO, etc.): Each time you make an appointment with Wells Allergy Associates physician, it is your responsibility to make sure the physician is currently under contract with your plan and you have obtained the necessary referrals when needed. Verification of your plan benefits/coverage is required. Often this verification requires us to share the reason for your visit with a managed care plan. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

We allow 45 days from the date a claim was filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for the entire balance without further notice. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co –insurance, co-payments, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Medicare: Wells Allergy Associates is a non-participant provider of Medicare. We are not a contracted provider of services for all Medicare plans.

Medicaid: Wells Allergy Associates is a contracted provider of some Medicaid insurance plans.

Method of Payment: For your convenience, Wells Allergy Associates will be happy to accept cash, Visa, MasterCard, Discover, or American Express for payment of your medical services. Wells Allergy Associates does not accept any checks for payment of services.

Minors: The parent(s) or guardian(s) of a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have authorization for medical treatment signed by a parent or guardian and is responsible for current insurance information for self and/or payment in full for services provided.

To assist us in updating your Wells Allergy Associates financial account, Please (1) provide current patient insurance information and (2) authorize release of information necessary for insurance filing and precertification by signing the statement below.

I have read and understand the above terms and conditions and will verify so by giving my signature.

____________________________________ ______________

Signature **Date**

Insurance Assignment and Authorization to Release Information

I request payment of authorized Medicare/Medicaid/Other Insurance company benefits be made on my behalf to Wells Allergy Associates for any services furnished me by that party who accepts assignments/physician. Regulations pertaining to Medicare Assignment of Benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the above mentioned party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

____________________________________ ______________

Signature **Date**

Statement of Coverage: I hereby attest that I do NOT have additional health care coverage afforded to me other than the primary insurance supplied by myself or legal guardian at the time of my appointment.

____________________________________ ______________

Signature **Date**

I acknowledge that I have received a copy of Wells Allergy Associates Notice of Privacy Practices for Protected Health Information.

Name of Patient: __________________________ **Patient Date of Birth:** ________________

____________________________________ ______________

Signature **Date**

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Your Rights as a Patient

- Courteous, professional, and knowledgeable staff
- Efficient evaluations of your conditions
- Educational instruction tailored to your specific needs
- Prompt and adequate follow-up of labs/procedures at your follow-up visit
- Cooperative management of your conditions

Our Requests of our Patients

- Please arrive 15 minutes prior to your scheduled visit to handle paperwork/payments
- Kindly provide 24 hour notice if you need to reschedule an office visit AND 48 hours notice if you need to reschedule a procedure visit
- NO gum, food, or drinks allowed in the clinic (another patient may have an allergy to your food items)
- NO strong odors (cigarette smoke, etc), perfumes/colognes that may offend or exacerbate another patient's condition-you may be asked to leave and return after the offending odor has resolved

CLINIC RULES

1. All copays/deductibles/co-insurances/debt/past due balances/payments are due **BEFORE** you are seen for your office visit/procedure
2. If you are more than 15 minutes late for your appointment, your appointment may be rescheduled
3. All refills are handled through your Pharmacy. We do **NOT** accept a patient calling in for a refill
    - **Please call your pharmacy and have them call our office for refill requests**
    - **Any refill requests received after 5pm will be handled the NEXT office business day**
    - **It may take up to 24 hours to refill a prescription request during the work week**
    - **No prescriptions will be refilled on the weekend or clinic holidays**

*****Refills are handled during business hours daily*****

4. Lab results are given during follow-up clinic visits only
    - **No phone calls please requesting lab results**

*****You will be contacted IMMEDIATELY if your lab results are of a life threatening or urgent nature*****

5. **NO** antibiotic prescriptions will be called into a pharmacy unless the patient has been seen in our office in the previous 2 days with a clinical history that may warrant such prescriptions (Physician's discretion).
6. You will be charged $50 for non-life threatening calls after clinic hours. **IF you feel that you have an urgent situation or emergency after clinic hours, please call your primary care provider, dial 911, or go to the nearest emergency room for evaluation/treatment.**

I have read the Wells Allergy Associates Clinic Policy & Rules and agree to abide by these stated rules. I know that the policy & rules may change at any time without notice. Any new policy & rules changes will be posted for me to review in the clinic.

______________________________ ____________________

Patient or Guardian Signature Date

____

(Print) Patient or Guardian Signature

 Patient Name: