Lone Star Allergy
& Asthma Center

Welcome To Our Practice

Our Practice is dedicated to the improvement of health through education, primary prevention and scientifically proven therapeutic interventions. Our health service goals are to deliver high-quality, cost-effective and individualized care plans that promote the health and well-being of the patients we serve.

To expedite your first visit, please complete all online registration forms prior to your scheduled appointment. All new patient forms can be found on our website by clicking the following link http://dentonallergy.com/patientforms.html. Please click the yellow "Patient Portal" button found on our website www.DentonAllergy.com within the "Patient Forms" tab. You should complete all 3 forms, including **(1) New Patient Medical History**, **(2) New Patient Registration** and **(3) Acknowledgment & Authorization** forms. To access the patient portal, you should have received a temporary **Password** via email or alternatively, a **Registration Token**, when you called our office to pre-register for an appointment. If you do not have this information, please call our office at (940) 565-5900 and one of our friendly receptionists will be happy to assist you. If our website is down, please use https://dentonallergy.myezyaccess.com to access these forms. If you prefer to complete these forms on paper upon your arrival…….then plan to arrive at least **30 minutes** early to complete this process.

In order to help you make the most of your first appointment, we would like to take this opportunity to make several requests:

1. **All drugs containing an antihistamine must be stopped before your appointment in case the doctor recommends skin testing during your first visit.** Antihistamines are drugs that block the effects of histamine and are widely used to treat allergies and other ailments. These drugs can cause misleading test results (false negative results) if used prior to skin testing. Examples of antihistamines include: Allegra, Claritin, Zyrtec, Benadryl and many over-the-counter products that treat colds, flu, allergies and insomnia. Please refer to the list of histamine-blocking drugs on the next page with special attention to the number of days the drug should be discontinued prior to undergoing skin testing. In general, antihistamines should be discontinued 5 days before skin testing.

2. Some medications used to treat **DEPRESSION, ANXIETY**, and **INSOMNIA** may also interfere with your skin test results. If you are unsure whether a particular medication or product contains an antihistamine or other interfering substance, please contact our office for clarification and further instructions at **(940) 565-5900**. Never stop your depression or anxiety medicine without first consulting a physician.

3. If you are taking montelukast (Singulair) or inhaled asthma medications then you should **continue taking them as previously directed**. They will not affect your skin test results.

4. Please bring all medications that you are currently using to your first appointment, including all over-the-counter and other nutritional/herbal supplements.

5. Bring any medical records to your appointment that may be important. We recommend the following be brought to your appointment: sinus or chest x-ray films or reports, sinus or chest CT scan films or reports, laboratory results, any previous allergy testing or lung function tests (i.e. spirometry).

Please budget between **2-3 hours** for your initial appointment, especially if undergoing an evaluation for nasal allergies and/or asthma. Thank you for allowing us an opportunity to improve your health.

Medications That Can Block Skin Test Results

[If taking, STOP these drugs prior to skin testing]

Antihistamines		
Generic Name	**Brand Name(s)**	**Stop Drug**
alcaftadine	**Lastacraft** eye drops	**24 hours**
azelastine	**Dymista, AstePro** and **Astelin** nasal sprays, **Optivar** eye drops	**24 hours**
azatadine	Optimine	**7 days**
bepotastine	**Bepreve** eye drops	**24 hours**
brompheniramine	Bromphen, Bromphed PD and many others	**3 days**
carbinoxamine	Palgic, Palgic-DS, Rondec, Rondec-TR and Andehist-NR	**5 days**
cetirizine	**Zyrtec,** Zyrtec-D, Aller-Relief and many others	**5 days**
chlorpheniramine	**Chlor-Trimeton**, Chlorphen and many others	**3 days**
clemastine	Allerhist-1, **Contac** 12-Hour Allergy and **Tavist**	**7 days**
cyproheptadine	Periactin	**5 days**
desloratadine	**Clarinex** and Clarinex-D	**5 days**
dexchlorpheniramine	Polaramine	**3 days**
diphenhydramine	**Benadryl**, Actifed Sinus Day, Aler-Dryl, Compoz Nightime Sleep Aid, Dephedryl, Diphen, **Nytol**, **Tylenol PM**, Unisom sleepgels, **ZzzQuil** and many other cold, flu and sleep remedies	**3 days**
doxylamine	**NyQuil** and many others	**3 days**
fexofenadine	**Allegra,** Allegra-D, Mucinex Allergy and many others	**5 days**
hydroxyzine	**Vistaril** and **Atarax**	**5 days**
ketotifen	**Zaditor** and **Zyrtec** Allergy eye drops but also many others	**24 hours**
levocetirizine	**Xyzal**	**5 days**
loratadine	**Claritin, Alavert**, Tavist ND and many others	**5 days**
olopatadine	**Patanase** nasal spray, **Pataday** and **Pazeo** eye drops	**24 hours**
tripelennamine	Pyribenzamine	**3 days**
Other Drugs with Antihistamine Activity		
Drug Class	**Generic Name**	**Stop Drug**
Anti-Nausea	Antivert (meclizine), Phenergan (promethazine), Compazine (prochlorperazine)	**3 days**
Antacids	ranitidine* (Zantac AC), famotidine* (Pepcid), cimetidine* (Tagamet), nizatidine* (Axid)	**24 hours**
Herbal Supplements	licorice, green tea, saw palmetto, St. John's Wort, feverfew	**3 days**
Psychotropic Medications	Antidepressants: **amitriptyline**, **imipramine**, **nortriptyline**, **doxepin**, **mirtazapine.** Antipsychotics: **quetiapine**, **chlorpromazine**, **haloperidol.** Anxiolytics/Hypnotics: **clonazepam**, **diazepam**, **lorazepam**, **temazepam**, **alprazolam**, bupropion*, trazodone*, eszopiclone* (Lunesta), zolpidem* (Ambien).	**discuss with your doctor**

*showed minimal interference with immediate hypersensitivity skin test histamine response

New Patient Medical History

Only complete this form if the digital version was not completed online within the Patient Portal	
Patient Name:	**Date of Birth:**
Patient Nickname:	**Patient Age:**
If patient is a minor then [Mother's Name]:	[Father's Name]:
Parents of the minor are: ☐ Married ☐ Divorced ☐ Separated ☐ Other:	
Primary Physician:	Referring Physician:
How did you hear about us? (Check the box that applies most)	
☐ Physician ☐ Family/Friend ☐ Insurance Plan ☐ Internet Search ☐ Phone Book ☐ Other:	

MAIN PROBLEM

Briefly describe, in your own words, the main reason for your visit?

How long have you had this problem and what is your main goal for this visit?

REVIEW OF SYMPTOMS

Check-off all symptoms which apply to the patient

General:	☐ fatigue	☐ drowsiness	☐ headache	☐ fevers	☐ chills	☐ sweats
	☐ body aches	☐ malaise	☐ weight loss	☐ weight gain	☐ other:	
Eyes:	☐ itchy eyes	☐ watery eyes	☐ drainage	☐ eye redness	☐ swollen	☐ crusting
	☐ eyelid swelling	☐ eyelid scaling	☐ dry eyes	☐ gritty eyes	☐ eye pain	☐ blurry vision
	☐ vision loss	☐ other:				
Ear, Nose & Throat:	☐ snoring	☐ nasal congestion	☐ itchy nose	☐ runny nose	☐ sneezing	☐ clear drainage
	☐ colored drainage	☐ sinus infections	☐ ear infections	☐ itchy ears	☐ ear pressure	☐ itchy throat
	☐ hoarseness	☐ sore throat	☐ throat clearing	☐ decreased smell	☐ nosebleeds	
	☐ other:					
Chest:	☐ cough	☐ wheezing	☐ chest tightness	☐ chest heaviness	☐ shortness of breath	☐ excessive sputum
	☐ coughing up blood	☐ other:				
Gastro-intestinal:	☐ heartburn	☐ sour burps	☐ nausea	☐ vomiting	☐ diarrhea	☐ constipation
	☐ abdominal pain	☐ abdominal cramps	☐ abdominal bloating	☐ swallowing issues	☐ gas	☐ bowel habit change
	☐ black stools	☐ bloody stools	☐ yellow skin	☐ other:		
Skin:	☐ skin rash	☐ itchy skin	☐ eczema	☐ hives	☐ dry skin	☐ skin infections
	☐ other:					
Additional Symptoms:						

SYMPTOM TRIGGERS

What makes your symptoms get worse? (Check-off any box below that may trigger your symptoms)

Allergy/ENT	Asthma/Chest	Eczema/Hives/Skin	Comments:
☐ does not apply	☐ does not apply	☐ does not apply	
☐ unknown	☐ unknown	☐ unknown	
☐ all year long	☐ all year long	☐ all year long	
☐ spring	☐ spring	☐ spring	
☐ summer	☐ summer	☐ summer	
☐ fall	☐ fall	☐ fall	
☐ winter	☐ winter	☐ winter	
☐ house dust	☐ house dust	☐ sweating	
☐ cats	☐ cats	☐ dry skin	
☐ dogs	☐ dogs	☐ heat	
☐ mowing the lawn	☐ mowing the lawn	☐ cold	
☐ mulching the garden	☐ mulching the garden	☐ medicine or drugs	
☐ food	☐ food	☐ food	
☐ smoke	☐ smoke	☐ personal products	
☐ strong odors	☐ strong odors	☐ scratching	
☐ exercise	☐ exercise	☐ exercise	
☐ indoors	☐ infections	☐ infections	
☐ outdoors	☐ emotional stress	☐ emotional stress	
☐ see comments	☐ see comments	☐ see comments	

New Patient Medical History

ALLERGY & ASTHMA HISTORY

Please answer the following questions

Question			
1) Have you ever been tested for allergies? If YES, then what tested positive:	☐ No	☐ Yes	If YES, then when (year):
2) Have you ever been treated with allergy shots? If YES, did allergy shots help you?	☐ No ☐ No	☐ Yes ☐ Yes	If YES, then from { } to { } ☐ Maybe If YES, then by whom:
3) Have you ever had a CT scan of the sinuses? If YES, was sinus CT normal? If NO or NOT SURE, explain:	☐ No ☐ No	☐ Yes ☐ Yes	If YES, then when (year): ☐ Not Sure
4) Have you ever had nasal or sinus surgery?	☐ No	☐ Yes	If YES, then when (year):
5) Have you ever had a reaction to food? If YES, was reaction treated in the ER? If YES, please describe reaction:	☐ No ☐ No	☐ Yes ☐ Yes	If YES, then what foods:
6) Have you ever had an insect sting reaction? If YES, was reaction treated in the ER? If YES, please describe reaction:	☐ No ☐ No	☐ Yes ☐ Yes	If YES, then what insects:
7) Have you ever been diagnosed with asthma?	☐ No	☐ Yes	If YES, then when (year):
If you answered "YES" to question 7 above, then answer questions 8 - 11 below about your asthma			
8) Any ER visits for asthma over the past year?	☐ No	☐ Yes	If YES, then how many visits:
9) Have you ever been hospitalized for asthma? If YES, then how many and in what year(s)? If YES, did hospitalization result in an ICU stay?	☐ No ☐ No	☐ Yes ☐ Yes	
10) Any missed school or work due to asthma?	☐ No	☐ Yes	If YES, total # of days over the past year:
11) Any oral steroid use over the past year?	☐ No	☐ Yes	If YES, total # of courses over past year:

Allergy and asthma history comments (if any):

INFECTION & IMMUNOLOGICAL HISTORY

Please answer the following questions

Question		
1) Are all recommended immunizations up-to-date?	☐ Yes	☐ No
2) Has lab work ever been done to evaluate the function of your immune system?	☐ No	☐ Yes
3) Has intravenous antibiotic therapy ever been required to clear a serious infection?	☐ No	☐ Yes
4) Have oral antibiotics ever been used for 8 weeks or longer with little or no benefit?	☐ No	☐ Yes
5) Have any antibiotic treatments been prescribed for the patient over the past year? If YES, then how many courses have been prescribed for the patient over the past year:	☐ No	☐ Yes

6) Have you had any of the following types of infections over the past 12 months?

Infection			
Sinus infections:	☐ No	☐ Yes	If YES, then how many over the past year:
Ear infections:	☐ No	☐ Yes	If YES, then how many over the past year:
Bronchitis:	☐ No	☐ Yes	If YES, then how many over the past year:
Pneumonia:	☐ No	☐ Yes	If YES, then how many over the past year: If YES, then how many episodes of pneumonia over lifetime:
Skin or organ abscesses:	☐ No	☐ Yes	
Oral or cutaneous thrush:	☐ No	☐ Yes	
Other types of infections:	☐ No	☐ Yes	

Infection and immunology history comments (if any):

New Patient Medical History

ENVIRONMENTAL HISTORY

Please answer the following questions

1) Does patient have any routine exposure to environmental tobacco smoke? ☐ No ☐ Yes

2) Does patient have any routine exposure to pets or other animals?
If YES, then what type(s) of animals:

3) Birthplace of patient: 3b) Living in Texas since (year):

4) Living in current residence since (year): 4b) Year in which current residence was built:

5) Description of current residence or work environment: (check-off all that apply)

☐ house (single family)	☐ apartment/multi-unit dwelling	☐ manufactured (mobile)	☐ pier & beam foundation
☐ basement	☐ carpet	☐ wood burning stove/fireplace	☐ water damage/mold growth
☐ indoor plants	☐ indoor pets	☐ rodents	☐ cockroaches/other insects
☐ central HVAC	☐ window AC unit(s)	☐ other notable feature	☐ unknown

6) Description of current sleeping area (bedroom): (check-off all that apply)

☐ spring or pillow-top mattress	☐ memory foam mattress	☐ sleep number mattress	☐ water bed
☐ feather pillow or comforter	☐ carpet	☐ stuffed toys	☐ curtains or drapes
☐ pets allowed in bedroom	☐ pets sleep on the bed	☐ rodents	☐ cockroaches/other insects
☐ air cleaner	☐ ceiling fan	☐ other notable feature	☐ unknown

FAMILY, WORK & SOCIAL HISTORY

Check-off the corresponding boxes and list any medical problems below if it applies

Relationship	Healthy	Allergy	Asthma	List of Other Medical Problems
Mother:	☐	☐	☐	
Father:	☐	☐	☐	
Sister:	☐	☐	☐	
Brother:	☐	☐	☐	
Daughter:	☐	☐	☐	
Son:	☐	☐	☐	

Patient occupation: Second job (if any):

Hobbies, additional work history or comments (if any):

Education level:

Smoking status: ☐ never smoker ☐ former smoker ☐ current smoker

If former or current smoker, then how many packs per day:
If former or current smoker, then for how many years:
If former smoker, then in what year did you stop smoking:

Additional social history of comments (if any):

Only complete this section if the patient is less than 10 years old

BIRTH & EARLY CHILDHOOD HISTORY

Question			Follow-up
1) Was the patient born early or premature?	☐ No	☐ Yes	If YES, was infant placed on a ventilator?
2) Was or is the patient breast fed?	☐ No	☐ Yes	If YES, then for how many months?
3) Did the patient ever have colic?	☐ No	☐ Yes	If YES, then what age did it resolve?
4) Did the patient ever have reflux?	☐ No	☐ Yes	If YES, then did patient require medication?
5) Did patient ever contract RSV?	☐ No	☐ Yes	If YES, did it require hospitalization?
6) Did the patient ever develop eczema?	☐ No	☐ Yes	If YES, then what age did it first develop?
7) Has patient ever attended day care?	☐ No	☐ Yes	If YES, then at what age did they start? If YES, is attendance ongoing?
8) Did patient have normal growth & development?	☐ Yes	☐ No	If **NO**, explain:

Additional birth & early childhood history comments (if any):

New Patient Medical History

PAST MEDICAL & SURGICAL HISTORY			
List all medical conditions including the year the diagnosis was initially made			
Medical Condition	Year	Medical Condition	Year
(1)		(8)	
(2)		(9)	
(3)		(10)	
(4)		(11)	
(5)		(12)	
(6)		(13)	
(7)		(14)	
List all surgical and sinus procedures including the year the procedure was performed			
Surgical Procedure	Year	Surgical Procedure	Year
(1)		(6)	
(2)		(7)	
(3)		(8)	
(4)		(9)	
(5)		(10)	

CURRENT MEDICATION LIST & DRUG ALLERGIES			
Please complete if you currently use any prescription, over-the-counter or herbal medications			
Name of Medicine	Dose	How Often Do You Take It	What Year Did You Start This Medicine
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			
(7)			
(8)			
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			
(25)			

Please complete the following section if you have any medication allergies		
Name of Medicine	Reaction Symptoms	Year of Reaction
(1)		
(2)		
(3)		
(4)		
(5)		

Lone Star Allergy & Asthma Center

New Patient Registration Form

PATIENT INFORMATION

Full Legal Name (First)	(MI)	(Last)	(Nickname)

Street Address (No.) (Street Name)	(Apt.)	Date of Birth (M/D/YYYY)	Age	Sex

City	State	Zip Code	Social Security Number	Ethnicity or Race

Home Phone ☐	Cell Phone ☐	Work Phone (including Ext.) ☐ Ext.	E-mail Address ☐

Check the corresponding box above indicating your preferred method of communication. Please Note: E-mail communications require a separate consent.

Referring Doctor (Name & Address)	(Name of Preferred Pharmacy)
Primary Care Doctor (Name & Address)	(Phone Number of Preferred Pharmacy)

Emergency Contact Person (Name)	(Phone Number)	(Relationship to Patient)

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (First)	(MI)	(Last)	(Phone Number)

Street Address (No.) (Street Name)	(Apt.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Patient's relationship to the Responsible Party

INSURANCE INFORMATION

Primary Insurance Company (Name)	(Insured's/Subscriber's ID or Member No.)	(Insured's Group No.)

Primary Insurance Company (Claims Address)	(Phone Number)

Insured's Name (First)	(MI)	(Last)	Patient's relation to the Insured? ☐ Self ☐ Spouse ☐ Dependent

If the Insured or Subscriber is not the Patient or Responsible Party, then complete the requested information below:

Insured's (Street Address)	(Apt.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Insured/Subscriber's Relationship to the Patient

If the Patient is covered by a Secondary Insurance Policy, then complete the requested information below:

Secondary Insurance Company (Name)	(Insured's/Subscriber's ID or Member No.)	(Insured's Group No.)

Secondary Insurance Company (Claims Address)	(Phone Number)

Insured's Name (First)	(MI)	(Last)	Patient's relation to the Insured? ☐ Self ☐ Spouse ☐ Dependent

If the Insured or Subscriber of the Secondary Insurance is not the Patient or Responsible Party, then complete the requested information below:

Insured's (Street Address)	(Apt.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Insured/Subscriber's Relationship to the Patient

Acknowledgement & Authorization

Receipt of "Notice of Privacy Practices"

I have received, read, and understand the "Notice of Privacy Practices" for Lone Star Allergy & Asthma Center. All questions that I have concerning the Notice have been answered to my satisfaction. I hereby authorize Lone Star Allergy & Asthma Center to use and disclose my **protected health information** or **PHI** in accordance with the said Notice. My requested restrictions to the use and disclosure of my PHI, if any, are as follows:

I hereby authorize the following entities, if any, to receive my PHI until revoked by me in writing:

NAME OF ENTITY	RELATIONSHIP

Acknowledgement

(Initial This Box)

X

Receipt of "Medical Services Financial Agreement"

I have received, read, and understand the "Medical Services Financial Agreement" of Lone Star Allergy & Asthma Center. All questions that I have concerning the Financial Agreement have been answered to my satisfaction. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred.

Acknowledgement

X

Acknowledgement of Accuracy

I hereby state that all personal identifying and health insurance information that I have provided to Lone Star Allergy & Asthma Center is true and correct to the best of my knowledge. I also agree that it is my responsibility to notify Lone Star Allergy & Asthma Center if any of this information changes prior to receiving future healthcare services.

Acknowledgement

X

Assignment of Benefits

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby assign, transfer, and set over payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

Acknowledgement

X

I have acknowledged the statements above regarding the ***Notice of Privacy Practices***, the ***Medical Services Financial Agreement***, the ***Accuracy*** of my personal information, and the ***Assignment*** of my insurance benefits to my physician by affixing my initials next to the said statements. All questions that I have concerning these statements or the documents referred to within have been answered to my satisfaction. I hereby state that I have read and understand the above statements and I have affixed my signature below attesting to the same.

______________________	______________	X______________________	____________
Printed Name of Patient	Date of Birth	Signature of Patient, Parent or Legal Guardian	Today's Date