Florida Medical Clinic, P.A.
Allergy, Asthma & Immunology

Daniel A. Reichmuth, M.D. and Sami Nallamshetty, M.D.
Diplomates of
The American Board of Allergy and Immunology
A Conjoint Board of
The American Board of Pediatrics and the American Board of Internal Medicine

We appreciate the confidence you have placed in us, and our staff will work together as a team to provide you with the highest quality treatment.

Our allergists are trained medical specialists, completing a lengthy process including college, four years of medical school, three years of residency, two years of allergy and clinical immunology fellowship and one year of clinical laboratory-immunology. They are board certified by the American Board of Allergy and Immunology, a conjoint Board of the American Board of Pediatrics and the American Board of Internal Medicine.

Enclosed are several forms we would like you to complete prior to coming to your appointment. The information you provide is essential to us for your medical evaluation and to our office staff for establishing your medical records and billing your insurance. Please bring completed forms with you for your initial visit, along with your insurance cards and photo identification so that we may copy them for your file.

If you anticipate allergy testing may be a necessary part of your visit with us, you may want to call the customer service phone number listed on your insurance card prior to coming to your appointment to be certain allergy testing is a covered benefit. If we can be of assistance in providing information to help you do this, please let us know. If your insurance company requires an authorization for this office visit, please contact your primary doctor and ask them to fax the referral to us at (813) 355-5043.

Our allergists do not double book appointments. If you do not show to your appointment, there will be a $50 charge that will need to be paid prior to making another appointment. We ask that you please give us a 24 hour notice for any appointment cancellations so another patient that may have an important medical need may be seen in that time slot.

We treat everyone that is seen in our office with courtesy and respect; we expect the same courtesy and respect in return. Racial and/or ethnic slurs, foul language or any inappropriate behavior will not be tolerated.

Should you require any forms to be completed or special reports dictated, there will be a fee for these services of $10 to $50 depending on the complexity of the forms/reports and the amount of time necessary for the physician to complete them.

If you have any questions or concerns, please feel free to call our office and we will be glad to assist you in any way possible. We will continually strive to provide you with the finest healthcare available.

Sincerely,
The Allergy, Asthma & Immunology Department at Florida Medical Clinic
PATIENT INFORMATION

FIRST NAME ____________________________ MIDDLE ____________________________ LAST NAME ____________________________

LOCAL ADDRESS _______________________________ DATE OF BIRTH _______ / _______ / _______ SEX _______

CITY ___________________ STATE _____ ZIP __________ EMAIL ADDRESS ________________________________

SOCIAL SECURITY ____________________________ CELL PHONE ( ) ____________________________

ETHNICITY: ____ NOT HISPANIC/LATINO _____ HISPANIC/LATINO _____ REFUSED

RACE: _______ AMERICAN INDIAN/ALASKA NATIVE __ ASIAN __ WHITE __________________

______ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

______ OTHER ____ OTHER SPECIFIED ____________________________

PREFERRED LANGUAGE ________________________________ PHONE ( ) ____________

____ MARRIED ____ SINGLE ____ WIDOWED ____ DIVORCED EMPLOYER ____________________________

____ EMPLOYED ___ RETIRED ___ FULL TIME STUDENT ADDRESS ________________________________

PERMANENT ADDRESS

ADDRESS _______________________________ CITY ___________________ STATE _____ ZIP _______

EMERGENCY CONTACT

NAME _________________________________ HOME PHONE ( ) ____________

RELATIONSHIP _______________________________ WORK PHONE ( ) ____________

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _______________________________ SEX _______ DAYTIME PHONE ( ) ____________

FIRST NAME ___________________ MIDDLE _______________ EMPLOYER ____________________________

LAST NAME _______________________________ ADDRESS ________________________________

ADDRESS _______________________________ CITY _______________ STATE _____ ZIP _______

CITY ___________________ STATE _____ ZIP _______

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES PLEASE COMPLETE THIS SECTION

NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKMAN COMPENSATION ☐ AUTOMOBILE ☐ OTHER

DATE OF ACCIDENT _______ / _______ / _______ Place of accident ___________________ How did accident happen? ___________________

CLAIM # ___________________ CLAIM REPRESENTATIVE/ADJUSTER ____________

IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME ____________________________ EMPLOYER PHONE( ) ____________

ADDRESS _______________________________ CITY _______________ STATE _____ ZIP _______

INSURANCE INFORMATION PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY ____________________________ INSURED’S DOB ____________________________

INSURANCE/CARD HOLDER’S NAME ____________________________ RELATIONSHIP ____________________________

ID# ___________________ GROUP # ____________________________ PHONE ( ) ____________

SECONDARY INSURANCE INFORMATION INSURANCE COMPANY ____________________________ RELATIONSHIP ____________________________

ID# ___________________ GROUP # ____________________________ PHONE ( ) ____________

SIGNATURE ___________________ DATE ____________________________

FORM: FMC00001.112008
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. Notice of Privacy Practices prior to signing this document. The Florida Medical Clinic, P.A. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The Notice of Privacy Practices for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This Notice of Privacy Practices also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Lifetime Authorization: By signing below 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, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Florida Medical Clinic, P.A.

I may obtain a revised Notice of Privacy Practices by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

Initials ________
Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department.

Acknowledgement of Receipt

Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic’s Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPPA) and FMC’s policies on use and disclosure of my protected health information.

______________________________  _________________________________
Name of Patient                Name of Guardian or Personal Representative

______________________________  _________________________________
Signature of Patient            Signature of Guardian or Personal Representative

______________________________
Date

Florida Medical Clinic, P.A.
Zephyrhills, FL  33542

cg / FMC Consent for Treatment, Payment & Health Care Operations
Florida Medical Clinic, P.A.
Authorization to Share Protected Health Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Second Form of Identification (SS#/DOB/Account#)</th>
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<tbody>
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I authorize the physicians and staff of:

- [ ] All FMC Departments
- [ ] The following FMC Departments

Specify:

- 
- 
- 

for protected health information with the following persons:

<table>
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<tr>
<th>Name</th>
<th>Relationship</th>
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This includes (please check all areas that apply):

- [ ] All Medical Information
- [ ] Hospital Information
- [ ] Lab Results
- [ ] Insurance Information
- [ ] X-ray Results
- [ ] Dialysis Clinic Information
- [ ] Medication (RX Renewal and Pickup)
- [ ] Appointment Information
- [ ] Telephone Consults
- [ ] Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature ________________________________ Date __________________________

Witness _________________________________________
### Allergy and Asthma Questionnaire

**Florida Medical Clinic Allergy, Asthma & Immunology**

Daniel A. Reichmuth, M.D.
38103 Market Square Zephyrhills, FL 33542
2241 Green Hedges Way Suite 101 Wesley Chapel, FL 33544
Tele (813) 779-8194; FAX (813) 355-5043

Sami Nallamshetty, M.D.
12500 N Dale Mabry Hwy, Tampa, FL 33618
2241 Green Hedges Way Suite 101 Wesley Chapel, FL 33544
Tele (813) 388-6855; FAX (813) 355-5894

To be filled out by the patient or the parent/guardian of the minor child. The following questions will help to determine the cause of your allergy and/or asthma symptoms. It is important to answer each question to the best of your knowledge and as accurately as possible.

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>________________________________</th>
<th>Age</th>
<th>Sex</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>________________________________</th>
<th>Date of Appointment:</th>
<th>________________________________</th>
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</table>

<table>
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<tr>
<th>Referring Physician:</th>
<th>________________________________</th>
<th>Primary Care Physician</th>
<th>________________________________</th>
</tr>
</thead>
</table>

**Briefly describe the reason for your allergy visit and what you hope to accomplish?**

---

### YOUR SYMPTOMS: Please check or circle all that applies to you:

#### Constitutional, □ none, other:
- □ Weight: Gain or Loss
  - If so how much? ___ what time frame ___

#### Endocrine, □ none, other:
- □ More tired than normal

#### Skin, □ none, other:
- □ Dryness, itching
- □ Eczema

#### Head/Neurologic, □ none, other:
- □ Headache (sinus/other ___)

#### Respiratory/Cardiovascular, □ none, other:
- □ Wheeze (with rest / with activity)
- □ Night, nights per week? ___
- □ With exercise or laughter
- □ Cough (day/ night, with exercise)
- □ Dry □ Productive, color?
- □ Day
- □ Night, nights per week? ___
- □ With exercise or laughter
- □ Shortness of breath
- □ Chest tightness
- □ Chest symptoms per week, ___ days

#### Ears, □ none, other:
- □ Itching, rubbing
- □ Redness, puffiness, discharge

#### Lymphatic, □ none, other:
- □ Swollen glands?, where? ______

#### Nose/Allergic, □ none, other:
- □ Less sense of smell
- □ Snoring
- □ Clear / Discolored
- □ Thin / Thick
- □ Constant / Seasonal
- □ Itching, rubbing
- □ Stiffness (constant / seasonal)
- □ Nose bleeds, last episode? ___
- □ Sneezing, how many times in a row? ___

#### Throat/Allergic, □ none, other:
- □ Itch
- □ Trouble swallowing
- □ Clearing throat, hoarseness
- □ Post nasal drip (clear/ white/ other
- □ Sore throat

#### Ears/Allergic, □ none, other:
- □ Popping or congestion
- □ Itching

#### Stomach, □ none, other:
- □ Heartburn, reflux, GERD
- □ Times per week? ___

#### Psychiatric, □ none, other:
- □ Anxiety

---

Physician’s Signature

Date
YOUR ALLERGY AND ASTHMA TRIGGERS

Please circle or check all the exposures that seem to worsen your allergy symptoms

Where are your symptoms triggered?  Inside  Outside  Same-both
Which seasons or times of the year do your symptoms occur?
- Spring
- Summer
- Fall
- Winter
- Continuous
When, during the day, are your symptoms the worst?
- First thing in the morning (upon waking)
- Later in the day
- Nighttime
Pets?:  Cats?  □ Yes  □ No
- Dogs?
- Other Pets?/Animals?, Please Specify:
Exercising or physical exertion?  □ Yes  □ No
Cold weather?  □ Yes  □ No
“Colds” or respiratory viruses?  □ Yes  □ No
Strong smells, such as tobacco smoke, perfumes, scented candles, cleaning agents?  □ Yes  □ No
Aspirin or other antiinflammatory pain medications such as ibuprofen?  □ Yes  □ No
Musty or moldy smells?  □ Yes  □ No
Sweeping, dusting or vacuuming?  □ Yes  □ No
Other, please specify:

PAST ALLERGY TESTING

Have you ever been allergy tested either with a skin or blood test?  □ Yes  □ No
If so, when?

And what were you found to be allergic to?

PAST ALLERGY IMMUNOTHERAPY (ALLERGY SHOTS)

Have you ever received allergy immunotherapy?  □ Yes  □ No
If so when and for how many months or years?
Have you ever had an adverse reaction to an allergy injection?  □ Yes  □ No
If so, what was the reaction?

MEDICATIONS YOU HAVE TRIED FOR YOUR ALLERGIES AND ASTHMA

Please list all the names (if known) and please note your response:

<table>
<thead>
<tr>
<th>Type of medication</th>
<th>Over-the-counter</th>
<th>Prescription</th>
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<tbody>
<tr>
<td>Antihistamines/eye drops, Singulair/Decongestant-such as Sudafed® or Tylenol Sinus®</td>
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<tr>
<td>Nasal sprays</td>
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<td>Asthma medication, inhalers</td>
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<tr>
<td>Other, please specify</td>
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</table>
### YOUR MEDICAL HISTORY

Frequent sinus infections? □ Yes □ No

How many times in a year?

Longest course of antibiotics?

Chronic Sinusitis (sinus infection lasting more than 6 weeks)? □ Yes □ No

Sinus X Ray or CAT scan? □ Yes □ No

<table>
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<tr>
<th>When</th>
<th>Where</th>
<th>Normal</th>
<th>Abnormal</th>
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How many times a year are you on an antibiotic for a respiratory infection (*including inner ear infection, bronchitis, pneumonia, sinus infection*)? □ Yes □ No

Nasal polyps? □ Yes □ No

Allergic rhinitis (Hay fever)? □ Yes □ No

Asthma?

# of school/work days missed during the last 1 year (approximate) for asthma ______

# of oral steroid (prednisone) prescriptions in the last 1 year (approximate) for asthma ______

# of ER visits in lifetime for asthma ______

History of life-threatening asthma attacks? □ Yes □ No

Intubated/ICU □ Yes □ No

Most recent chest X-ray?

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<tr>
<th>When</th>
<th>Where</th>
<th>Normal</th>
<th>Abnormal</th>
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Eczema or atopic dermatitis? □ Yes □ No

Infancy/Early childhood

History of egg or milk (or milk based formula) allergy-intolerance? □ Yes □ No

Colic or frequent spitting up? □ Yes □ No

Recurrent ear infections? □ Yes □ No

How many times in a year?

Respiratory problems? □ Yes □ No

Croup? □ Yes □ No

Recurrent chest infections? □ Yes □ No

Pneumonia?

If so, How many times?

Last episode?

Hospitalized ever?

| Tuberculosis? | □ Yes □ No |
| Kidney disease? | □ Yes □ No |
| Prostate disease? | □ Yes □ No |
| Liver disease? | □ Yes □ No |
| Glaucoma? | □ Yes □ No |
| Diabetes mellitus? | □ Yes □ No |
| Heart trouble? | □ Yes □ No |
| High blood pressure? | □ Yes □ No |

Other medical problems, please list:

---

**Past Surgery and Hospitalizations**

- Tonsils and/or adenoids removed? □ Yes □ No
- if so when?

- Tubes placed in ears? □ Yes □ No

- Nasal polyp removal? □ Yes □ No

- Sinus surgery? □ Yes □ No

Other:

**Vaccines**

- Influenza, if so: Last injection date
- Pneumovax, if so: Last injection date

Up-to-date on childhood and tetanus immunizations: □ Yes □ No
YOUR CURRENT MEDICATIONS

*Please list names of ALL your medications and include dose and how frequent medication is taken*

*Please also bring in actual medication bottles*

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<td>11.</td>
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<td>6.</td>
<td>12.</td>
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</table>

YOUR ALLERGIES AND INTOLERANCES

*Please list names, type of reaction and when they occurred*

☐ No known allergies

Medication(s)

Food(s)

Insect(s)

YOUR ENVIRONMENT

HOME

1. Make of home: Wood Block Manufactured

2. How old is the home?

3. How long have you lived in home?

4. Did the previous owner have pets? ☐ Yes ☐ No If Yes, Types?

5. Air Conditioning: Central Window unit None

6. Current or recent pets? ☐ Yes ☐ No

   What type and how many?

   Are they Inside Outside Both (inside at times)

7. How old is your mattress?

8. How old is your pillow?

9. Do you have special allergy covers for dust mite avoidance? ☐ Yes ☐ No

10. Do you have special air cleaners? ☐ Yes ☐ No

11. Which rooms have carpeting?

   None Living room Your Bedroom Other

12. Does your home have any obvious mold growth, musty smell, past floods or water leaks? ☐ Yes ☐ No

13. Does anyone smoke in the house or car? ☐ Yes ☐ No

14. Which state were you born in, and how long did you live there?

15. Other states you lived and how long?

16. How long have you lived in Florida?
1. Are there any exposures at work or school that worsen your symptoms? □ Yes □ No
2. Do you have any hobbies or outside activities that worsen your symptoms? □ Yes □ No
3. If you have traveled around the country, have there been any locations you have had a change in symptoms? □ Yes □ No
   If so where and had your symptoms worsened or improved?
4. Young children: Daycare? □ Yes □ No
   If yes, when did your child start attending daycare?

**SMOKING AND ALCOHOL USE**

□ Not applicable

**Smoking history**
Have you ever smoked? □ Yes □ No
   If so, When did you start?
Do you currently smoke? □ Yes □ No
   If Not, When did you stop?

Past or present: Average per day (ppd = pack of cigarettes per day)

<table>
<thead>
<tr>
<th>Less than ½ ppd</th>
<th>½ ppd</th>
<th>1 ppd</th>
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</thead>
<tbody>
<tr>
<td>1 ½ ppd</td>
<td>2 ppd</td>
<td>More than 2ppd</td>
</tr>
</tbody>
</table>

**Alcohol**
None | Rare | 1-2 week |
| 1-2 day | More than 2 day? | Amount? |

**YOUR FAMILY HISTORY**

<table>
<thead>
<tr>
<th>MEDICAL PROBLEM</th>
<th>FAMILY MEMBERS</th>
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<tbody>
<tr>
<td>Allergic rhinitis (hay fever)</td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Eczema</td>
<td></td>
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<tr>
<td>Emphysema</td>
<td></td>
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<tr>
<td>Heart disease</td>
<td></td>
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<tr>
<td>Cystic fibrosis</td>
<td></td>
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<tr>
<td>Autoimmune disease, such as lupus or rheumatoid arthritis</td>
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<tr>
<td>Immune deficiency</td>
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<tr>
<td>Thyroid disease</td>
<td></td>
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<tr>
<td>Other medical problems</td>
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</table>
!!ATTENTION!!
WE CARE FOR MANY PATIENTS WITH SENSITIVITIES TO STRONG SMELLS

PLEASE DO NOT WEAR PERFUME OR COLOGNE IN THIS OFFICE

WE THANK YOU FOR YOUR UNDERSTANDING AND COOPERATION!