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

Florida Medical Clinic

Your life. Our specialty.

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 HOME PHONE ( ) _____

RACE: ___ AMERICAN INDIAN/ALASKA NATIVE ___ ASIAN ___WHITE WORK PHONE ( ) _____

___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____

___ OTHER ___OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____

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 _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SIGNATURE _____ DATE _____

Florida Medical Clinic
Your life. Our specialty.

FLORIDA MEDICAL CLINIC, P.A.

Your Life, Our Specialty

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 _____

Florida Medical Clinic
Your life. Our specialty.

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

Patient Name:	Second Form of Identification (SS#/DOB/Account#)

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

_____

_____

_____

to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes (please check all areas that apply)

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

This authorization will be in effect until authorization is revoked.

Patient's Signature_____ Date_____

Witness _____

Hive, Swelling and/or Rash Questionnaire

Florida Medical Clinic Allergy, Asthma & Immunology

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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.

Patient's Name _____Age_____Sex_____

Date of Birth: _____ Date of Appointment: _____

Referring Physician: _____ Primary Care Physician _____

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

OTHER POSSIBLE SYMPTOMS
Are you currently or recently experiencing any of these problems

Mouth	**1.** Open sores in your mouth?: If so painful or painless?	☐ Yes ☐ No
Skin	**2.** Rash on your cheeks?	☐ Yes ☐ No
	3. Rash that is worse when you are in the sun?	☐ Yes ☐ No
	4. Other skin (other than the above problem) or hair changes? If so, please specify:	☐ Yes ☐ No
Musculoskeletal	**5.** Joints that hurt or are swollen?	☐ Yes ☐ No
	6. Feel stiff in the morning, if so for how many hours?	☐ Yes ☐ No
	7. Hand swelling?	☐ Yes ☐ No
Lymph nodes	**8.** Swollen glands or lymph nodes, if so where?	☐ Yes ☐ No
Respiratory	**9.** Sharp chest pain when you breathe in deep?	☐ Yes ☐ No
Urinary	**10.** Blood in your urine?	☐ Yes ☐ No
Endocrine	**11.** Unusual weight gain or weight loss?	☐ Yes ☐ No
Constitutional	**12.** Night sweats not associated with menopause?	☐ Yes ☐ No
	13. More fatigue than normal?	☐ Yes ☐ No
Gastrointestinal	**14.** Heartburn, reflux or GERD symptoms If so how many times a week ? _____	☐ Yes ☐ No
Allergic	**15.** Hayfever type symptoms?	☐ Yes ☐ No
Neurologic/ Psychiatric	**16.** Headaches?	☐ Yes ☐ No
	17. Anxiety?	☐ Yes ☐ No

_____ _____/_____/_____

Physician's Signature Date

YOUR SYMPTOMS

Are you currently or recently experiencing any of these problems

1. How would you describe your rash / hives / swelling?

2. Are the hives / rash / swelling:

Itchy Painful Sore

3. When did the hives / rash / swelling start?

4. How large are the welts/ rash?

Pinpoint size of penny size of quarter larger than quarter

5. Where do the hives / rash occur on the body?

Head Arms Legs

Chest Back Along areas of pressure (Bra strap or waistband)

Other, please specify:

6. Are the hives / rash associated with swelling? □ Yes □ No

If so, where does the swelling occur?

Around eyes Lips Tongue Throat Other, please specify

7. Are the hives / rash / swelling continuous or occur in episodes?

If occur in episodes, how many times a week?

8. How many hours does one individual welt / rash last?

Less than 12 hours 12 to 24 hours

24-48 hrs 48-72 hrs More than 72 hours

9. Do they leave a black and blue mark (bruise) after or when they are present? □ Yes □ No

10. What time of the day are they worse? Morning Noon Evening-Nighttime

11. Are they present when you wake up even before eating breakfast? □ Yes □ No

12. Have you had a recent infection (within one month of the start of the hives / rash / swelling), such as a sinus infection, "cold", other virus infection, other (please specify)? □ Yes □ No

13. Have you ever had this type of problem (rash/hives/swelling) before? □ Yes □ No

If so, When?

How long did they last (days, weeks, months, years)?

14. Have you ever had swelling of the lips, tongue, or throat without hives? □ Yes □ No

POSSIBLE TRIGGERS, Do any of these things make your hives / rash /swelling worse (or better)?

1. Food? ☐ Yes ☐ No

If so please specify possible or known foods:

2. Medication, including over the counter medications such as vitamins, aspirin, ibuprofen? ☐ Yes ☐ No

If so please specify possible or known medications:

3. Have you started any new medications within the month before the onset of the hives / rash / swelling? ☐ Yes ☐ No

If so please specify new medications, vitamins, or food supplements:

4. Things you touch or come in contact to, such as latex or pets (cats, dogs, horses, other)? ☐ Yes ☐ No

If so please specify possible or known contactants:

5. Drinking alcohol? ☐ Yes ☐ No

6. Becoming cold (outside air or cool water) or overheated? ☐ Yes ☐ No

7. Exercise? ☐ Yes ☐ No

8. Vibration, such as with an electric mixer or drill? ☐ Yes ☐ No

9. Pressure (waistband vs soles of feet or palms)? ☐ Yes ☐ No

10. Being out in the sun? ☐ Yes ☐ No

HAVE YOU TRIED ANY OF THESE TREATMENTS?, if so please note your response:
Totally relieved (TR) ***Improved (I)*** ***No change (NC)*** ***Worse (W)*** ***Not Tried (NT)***

1. Antihistamines (ie, Benadryl, Claritin, Alavert, Zyrtec, Allegra, Clarinex)? □ TR □ I □ NC □ W □NT

If so, please specify:

and did you take it every day (how many days in a row) or just when needed?

2. Steroids (prednisone or Medrol, such as "Dose Paks") □ TR □ I □ NC □ W □NT
If so, how many courses? And when did you take each course?

3. Creams, ointments, lotions?, If so please note medication name if known.

Steroid-based: □ TR □ I □ NC □ W □NT

Elidel or Protopic: □ TR □ I □ NC □ W □NT

Moisturizing: □ TR □ I □ NC □ W □NT

Other: □ TR □ I □ NC □ W □NT

3. Zantac or Pepcid or Tagamet? □ TR □ I □ NC □ W □NT

4. Singulair or Accolate? □ TR □ I □ NC □ W □NT

5. EpiPen? □ TR □ I □ NC □ W □NT

6. Other?, please specify: □ TR □ I □ NC □ W □NT

YOUR OTHER MEDICATIONS

Please list all of your other medications: name, dose, and how frequent medication is taken
Please also bring in actual medication bottles

YOUR ALLERGIES AND INTOLERANCES

Please list names, type of reaction and when they occurred

□ **No known allergies**

Medication (s)

Food (s)

Insect (s)

Your MEDICAL HISTORY

1. Do you have a history of hepatitis? □ Yes □ No

2. Do you have a history of any kind of autoimmune disease (such as lupus, rheumatoid arthritis) OR cancer (such as lymphoma or leukemia)? □ Yes □ No
If so please describe:

3. Do you have a history of thyroid problems? □ Yes □ No
If so please describe:

4. Other medical problems and surgeries, please list:

Family MEDICAL HISTORY

1. Thyroid problems? □ Yes □ No

2. Autoimmune disease, such as rheumatoid arthritis or lupus? □ Yes □ No

3. Swelling episodes? □ Yes □ No

4. Other?, please list:

SMOKING AND ALCOHOL USE □ Not Applicable

Smoking history

Have you ever smoked? □ Yes □ No

If so, When did you start?

Do you currently smoke?, if not:

When did you stop?

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

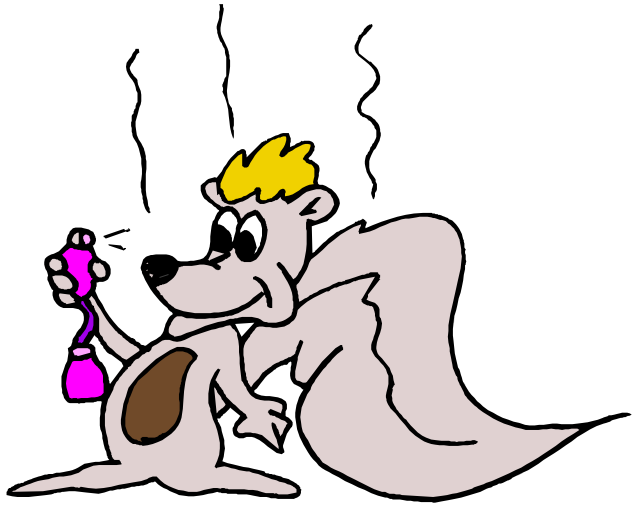
Less than 1/2 ppd	½ ppd	1 ppd
1 ½ ppd	2 ppd	More than 2ppd

Alcohol

None	Rare	1-2 week
1-2 day	More than 2 day?, if so: Amount?	

!!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 !