Medical History

Patient's Last Name:	First:	Middle Initial:	DOB

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Anemia	Breast Cancer	Heartburn / Acid Reflux	Thyroid Problems	Seizures
Anxiety	Colon Cancer	Hearing Loss	Leukemia	Stroke
Arthritis	COPD	Heart Disease	Lung Cancer	Other:
Asthma	Coronary Artery Disease	Hepatitis	Lupus	
Atrial Fibrillation	Depression	High Blood Pressure	Lymphoma	
Bone Marrow Transplant	Diabetes	HIV / AIDS	Prostate Cancer	
BPH	End State Renal Disease: **Y or N**	High Cholesterol	Radiation Treatment	

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Appendix	Heart (Biol Heart Replaced)	Liver Transplant	Skin Biopsy
Bladder	Heart (Coronary Artery ByPass)	Liver Shunt	Skin (Basal Cell Carcinoma)
Breast Biopsy	Heart Transplant	Ovaries (Endometriosis)	Skin (Squamous Cell Carcinoma)
Breast Lumpectomy Right / Left / Both	Heart (Mech Valve Replace)	Ovarian Cyst	Skin (Melanoma)
Breast Mastectomy Right / Left / Both	Heart (PTCA)	Ovaries (Tubal Ligation)	Spleen
Breast Reduction	Joint Replacement: **HIP** Right / Left / Both	Pancreas (Pancreatetcomy)	Testicles
Breast Implants	Joint Replacement: **KNEE** Right / Left / Both	Prostate Biopsy	Uterus (Uterine Cancer)
Colon Resection	Kidney Biopsy	Prostate Cancer	Uterus (Cervical Cancer)
Colon (Diverticulitis)	Kidney Stone Removal	Prostate (TURP)	Hysterectomy: Partial / Complete
Colon (Infl Bowel Disease)	Kidney Transplant	Rectum (APR)	Other:
Gallbladder	Kidney (Nephrectomy)	Rectum (Low Ant Resection)	

SKIN CONDITIONS PAST AND PRESENT: (PLEASE CIRCLE ALL THAT APPLY)

Acne	Dry Skin	Melanoma	Squamous Cell Skin Cancer
Actinic Keratosis	Eczema	Poison Ivy	Other:
Basal Cell Skin Cancer	Flaking / Itchy Scalp	Pre-Cancerous Moles	
Blistering Sunburns	Hay Fever / Allergies	Psoriasis	

Do you wear sunscreen: ❑ Yes ❑ No Do you tan in a tanning salon: ❑ Yes ❑ No

LIST CURRENT MEDICATIONS: (IF MEDICATIONS ARE CONTINUED ON BACK, MARK HERE ❑) **NONE ❑**

If you have a LIST, please give to front desk Medications	**Strength**	**Frequency**	**Start Date**

Medical History

Patient's Last Name:	First:	Middle Initial:	DOB:

MEDICATIONS YOU ARE ALLERGIC TO & REACTION: ❑ NONE

❑ Penicillin	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Sulfa Drugs	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash ,Other:
❑ Erythromycins	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Tetracyclines	Anaphylaxis(Throat Swelling), Angioedema(Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Codeine	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Other:	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:
❑ Other:	Anaphylaxis (Throat Swelling), Angioedema (Lips Swelling), Diarrhea, Fatigue, GI Upset, Hives, Rash, Other:

SOCIAL HISTORY:

Do you smoke: ❑ Yes ❑ No Have you ever smoked: ❑ Yes ❑ No

Do you drink alcohol: ❑ Yes ❑ No Frequency: ❑ Daily ❑ Weekly ❑ Monthly ❑ Social

Do you drink caffeine: ❑ Yes ❑ No Frequency: ❑ Daily ❑ Weekly ❑ Monthly ❑ Social

Do you exercise: ❑ Yes ❑ No Frequency: ❑ Daily ❑ Weekly ❑ Monthly

Has your pcp / cardiologist told you to take antibiotics before surgery: ❑ Yes ❑ No Church / Religious Preference:_____

What Pharmacy do you use: _____ Zip Code: _____

FAMILY HISTORY: (PLEASE CHECK ALL THAT APPLY)

	Mom	Dad	Sister	Brother
High Blood Pressure				
Heart Disease				
Thyroid Problems				
Diabetes				
Melanoma Skin Cancer				
Cancer:				
Other:				

PLEASE CIRCLE ALL THAT APPLY TODAY:

Epinephrine Hypersensitivity (Tachycardia)	Ear Pain	Heart Burn	Lidocaine Allergy
Sensitivity to Sunlight	Hoarseness	Hematochezia (Bloody Stool)	Defibrillator
History of Mucous Membrane Ulcerations	Nasal Congestion	Nausea	Pacemaker
Allergies (Nasal)	Nasal Discharge	Dysuria (Painful Urination)	Palpitations
Chills	Nose Bleeds	Hematuria (Bloody Urine)	Blood Thinners
Fever	Ringing in Ears	Headaches	Prolonged Bleeding
Night Sweats	Sore Throat	Vertigo / Dizziness	Pre-op Antibiotics Recommended
Unexplained Weight: LOSS / GAIN	Cough	Anxiety	Joint Swelling
Antibiotics Induce "YEAST" Infection	Shortness of Breath	Depression	Joint Pain
Fatigue	Asthma / Wheezing	Pregnant / Planning Pregnancy	Port-A-Cath
Dysequilibrium	Antibiotics – GI Intolerance	Breastfeeding	West Africa: TRAVEL or CONTACT

DYERSBURG SKIN & ALLERGY CLINIC

REGISTRATION FORM

(Please Print)

Today's date:	**Social Security #:**

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle Initial:**

Sex: ❑ M ❑ F	**Birth Date:**	**Age:**		**Marital status (circle one):** Single / Married / Div / Sep / Widow

Race / Ethnicity: ❑Caucasian / ❑African American / ❑Hispanic / Other:	**Language:** ❑English / ❑Spanish / Other:_____

Mailing Address:	**City:**	**State:**	**ZIP Code:**

Telephone #: ( )	**Cellular Telephone #:** ( )
Employer: ❑ **Unemployed** ❑ **Disabled** ❑ **Retired**	**Employer Telephone #:** ( )

Referred By: ❑ Dr. _____ ❑ Family ❑ Friend ❑Other: _____

Email Address:

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	**Relationship:** ❑ Child ❑ Friend ❑ Other:_____
Home Telephone #: ( )	**Cellular Telephone #:** ( )

INSURANCE INFORMATION

Primary Insurance: BCBS / Medicare / UHC / Cigna / UMR / Blue Care / Aetna / Other:	**Identification #:**	**Group #:**
Secondary Insurance: BCBS / Medicare / UHC / Cigna / UMR / Blue Care / Aetna / Other:	**Identification #:**	**Group #:**

Assignment of Benefits & Release Form

MY SIGNATURE AND DATE, ON THE LINE BELOW, AUTHORIZES EACH OF THE FOLLOWING:

1. Assignment of all Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Dr. Busch, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

2. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Busch for any services provided to me by the physician. I authorize the release of any necessary information to the Health Care Financing Administration to determine the benefits available for the service provided by my physician. I understand that by signing below, I am giving my physician / staff permission to request and collect payment. In addition, I am aware and authorize my physician to submit the medical and personal information necessary to collect payment. If other health insurance is indicated in item 9 of HCFA – 1500 Form, elsewhere on the other approved claim forms, or on electronically submitted claims, my signature authorizes release of the information to my insurer / agency. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

3. I authorize treatment and agree to pay any and all fees and charges for such treatment. I agree to pay all charges for members of my family shown by statements, promptly upon presentation. If your claim is not paid within 90 days, you will be expected to pay the balance for the date of visit concerned. If any incorrect information is given to us and your claim is denied, you will be expected to make full payment. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family, I agree to pay reasonable attorney's fee or other such cost as the Court determines proper.

_____ _____

Signature of Patient / Insured / Guardian Date

Acknowledgement of Privacy Practices & Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use and disclosure of their personal health information. Our Notice of Privacy Practices has been provided to you today. The patient understands that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) that:

- Protected health information may be used and disclosed to provide and coordinate treatment among a number of health care providers who may be involved in that treatment directly and indirectly, payment with your insurance company, or healthcare operations within our office.
- Dyersburg Skin & Allergy Clinic has a Notice of Privacy Practices that is available for review.
- The patient has the right to restrict the use of their information, but Dyersburg Skin & Allergy Clinic does not have to agree to these restrictions, if, for example, it interferes with payment, daily operations, or providing quality care. If we do agree, then we are bound to abide by such restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- Dyersburg Skin & Allergy may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service).

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, are as follows:

- The patient has the right to be notified of a protected health information breach.
- The patient has the right to ask for a copy of their electronic health record in electronic form.
- Dyersburg Skin & Allergy Clinic cannot sell a patient's health information without their permission.
- Certain uses of a patient's medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practices will only be made with a patient's authorization.

My signature confirms that I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses of disclosures of my protected health information. I have been offered a copy and therefore have been given the right to review such Notice of Privacy Practices; however, it is also available for review at the front desk and on our company website, www.dyersburgskinandallergyclinic.com.

Signature of patient / Insured / Guardian _____ Date _____

Allergy Testing & Treatment

This packet contains instructions for allergy testing and treatment. Please return all of this with you to your appointment.

Please bring the following with you to your appointment:

- Insurance Card / Cards
- Drivers License
- List of All Medications

DO NOT TAKE THESE MEDICATIONS ONE WEEK PRIOR TO TESTING:

- Antihistamines or anything containing an antihistamine
- Muscle Relaxers
- Tranquilizers or Tri-Cyclic Antidepressants
- Sedatives
- NSAIDs
- Over the counter sleeping medications
- Large doses of Vitamin C

MEDICATIONS THAT MAY BE TAKEN:

- Asthma medications
- Tylenol
- Prescriptions (except for those listed above)
- Sudafed
- Nasal Steroids
- Steroids

If you take beta blockers (see attached list), you cannot have allergy testing or injections. Please discuss this with the Allergy Department before your testing or injections. You will need to notify the staff if you have any cardiac problems, take cardiac medications, or have a pacemaker.

The skin testing appointment generally takes 1 ½ - 2 hours and will be an intra-dermal test on the arms. Please make sure to wear a short sleeve or sleeveless shirt. If it is necessary to cancel your test, please notify us 24 hours prior to the appointment. Please complete the history form and other paperwork you were given and bring with you to the appointment.

If you have any questions, please call us at (731)286-4300 and ask for the Allergy Department.

Thank you.

Allergy Testing & Treatment

BETA BLOCKERS	
Generic Name	**Brand Name**
Acebutolol	Sectral
Atenolol	Tenormin
Betaxolol	Kerlone, Betopic
Bisoprolol	Zenbeta
Esmolol	Brevibloc
Nebivolol	Bystolic
Metoprolol	Lopressor, Toprolol XL
Carteolol	Ocupress
Penbutolol	Levatol
Pindolol	Visken
Carvedilol	Coreg
Labetalol	Trandate
Levobunolol	Betagan
Metipranolo	OptiPranolol
Nadolol	Corgard
Propranolol	Inderal, Inderal LA, Innopran XL
Sotalol	Betapace, Blocadren, Istalol, Timoptic
Timolo	Brevibloc

EYE DROPS CONTAINING BETA BLOCKERS	
Generic Name	**Brand Name**
Levobunolol	Betagan, AK Beta
Betaxolol	Betoptic
Metipranolol	Potipranolol
Caretolol	Ocupress
Timolol	Timpotic

Please mark the appropriate choice and sign below:

☐ I am taking / using_____ from the medications listed above.

☐ I am not taking any of the medications listed above.

_____ _____

Signature of Patient / Guardian Date

Dyersburg Skin & Allergy Clinic, 1950 Cook Street, Ste, B, 710 Hwy 51 ByPass, Dyersburg, TN, 38024

Informed Consent For Allergy Immunotherapy

Allergy immunotherapy shots contain water extract of pollen, mold, or dust to which a patient has been shown to be allergic by skin testing. With any type of injections, as with other substances injected into the body, there may be a "shot reaction". These generally are mild and include:

- Burning or itching at the injection site
- Swelling or hives at the injection site
- Generalized hives (welts)
- Nasal congestions and / or "runny nose" with inching of ears, nose, or throat and / or sneezing
- Itchy, watery, or red eyes

Occasionally, more severe reactions include:

- Swelling of tissue around the eyes, tongue, or throat
- Stomach or uterine (menstrual-type) cramps
- Wheezing, cough, and shortness of breath

Rare complications are:

- Abnormalities of the heart beat
- Loss of ability to maintain blood pressure and pulse

Severe reactions involving the heart, lungs, and blood vessels, could be fatal. However, if recognized and treated early, the risk is reduced.

Experience has shown that the overwhelming majority of reactions which require emergency treatment occur within 30 minutes of an injection. It is for this reason that all patients who receive such injections must remain for 30 minutes in our waiting area until checked.

Punctuality and compliance are important! It is dangerous to deviate from the prescribed schedule as there is an increased risk of a complicated reaction to the allergen solution if it is given after a prolonged interval from the previous injection. For your own safety, you should keep your appointments.

I am aware that allergy injections MUST NOT be given to patients taking or using "Beta Blockers". I have been provided a list of beta blocker medications and am currently NOT taking one of these drugs. If I begin to take any of these medications in the future, I will inform the allergy nurse at that time. I understand that beta blockers increase the likelihood of a severe reaction and make those reactions more difficult to reverse.

I herby give consent to Dyersburg Skin & Allergy Clinic for allergy immunotherapy and I further consent to the performance of such additional procedures as are indicated and considered necessary in the judgment of the treating Physician, Nurse Practitioner, or Physician Assistant to treat any reactions to the allergy injection.

I have been fully informed of the risks connected with the performance of allergy immunotherapy.

IN SIGNING THIS STATEMENT, I ACKNOWLEDGE THAT I HAVE FULLY READ AND UNDERSTAND THE INFORMATION THAT IT CONTAINS, AND THAT I HAVE BEEN ABLE TO HAVE ANY QUESTIONS ANSWERED BY ONE OF THE ALLERGY NURSES, PHYSICIAN, OR PHYSICIAN ASSISTANT.

_____ _____

Signature of Patient / Guardian Date

Dyersburg Skin & Allergy Clinic, 1950 Cook Street, Ste, B, 710 Hwy 51 ByPass, Dyersburg, TN, 38024

ALLERGY QUESTIONNAIRE

How were you referred: ❑ Physician ❑ Self ❑ Other_____

What problem brings you to appointment today:

_____

_____

When did symptoms begin: _____

Have you been allergy tested before: ❑ Yes ❑ No

Have you had allergy treatment before: ❑ Yes ❑ No

Please check **ANY** conditions that you have had:

❑ Blocked Ears	❑ Hives / Swelling	❑ Sinus Infections
❑ Chest Tightness	❑ Itchy Nose	❑ Sneezing
❑ Cough	❑ Itchy / Watery Eyes	❑ Snoring
❑ Ear Infections	❑ Nasal Congestion	❑ Other
❑ Eczema	❑ Nasal Polyps	_____
❑ Excessive Phlegm	❑ Post-Nasal Drip	_____
❑ Fatigue	❑ Runny Nose	_____
❑ Headaches	❑ Shortness of Breath	_____

Please check ANY of the following that may TRIGGER your symptoms:

❑ Aerosol Sprays	❑ Horses	❑ Perfumes
❑ Basements	❑ House Dust	❑ Pollution
❑ Cats	❑ Humidity	❑ Smoke
❑ Cold Air	❑ Insecticides	❑ Weather Changes
❑ Cosmetics	❑ Leaves	❑ Other:
❑ Dogs	❑ Mold / Mildew	_____
❑ Grass	❑ Odors	_____
❑ Hay	❑ Other Animals	_____

Are your symptoms worse: ❑ Seasonally ❑ Year Round

When you are away from home, are your symptoms: ❑ Better ❑ Worse

Dyersburg Skin & Allergy Clinic, 1950 Cook Street, Ste, B, 710 Hwy 51 ByPass, Dyersburg, TN, 38024

ALLERGY QUESTIONNAIRE

Environmental Survey

Do you live in a: ❑ House ❑ Condo ❑ Townhouse ❑ Apartment ❑ Duplex

Where do you live? ❑ City ❑ Rural

Number of indoor plants:

Age of house:

House construction: ❑ Brick ❑ Wood ❑ Other:_____

Is your home / apartment excessively humid: ❑ Yes ❑ No

Any water leaks / mold contaminations: ❑ Yes ❑ No

Type of heating: ❑ Space Heater ❑ Baseboard ❑ Electric ❑Other:_____

Type of air conditioning: ❑ Central ❑ Window ❑ Other:_____

Flooring in your home: ❑ Carpet ❑ Wood ❑ Other:_____

Do you have any: ❑ Stuffed Furniture ❑ Feather Comforters

Is your pillow: ❑ Feather ❑ Foam ❑ Other:_____

Is your mattress: ❑ Foam ❑ Cotton ❑ Water ❑ Innerspring & Cotton ❑ Encased in Plastic ❑ Other:_____

Do you have pets: ❑ Dogs ❑ Cats ❑ Other:_____

How Old is Your Mattress: _____

Problems with roaches or mice: ❑ Yes ❑ No

Past Medical History

Any Hospitalizations:

Have you had your tonsils or adenoids removed: ❑ Yes ❑ No

Have you had ear / nose / throat surgery: ❑ Yes ❑ No

Food Allergies and Reactions Experienced:

Drug Reactions Experienced: ❑ Penicillin _____ ❑ Sulfa _____ ❑ Aspirin _____ Other: _____

Describe any reactions to insect stings:

Check all that apply to you:

- ❑ Diabetes
- ❑ Heartburn / Reflux
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Migraines
- ❑ Asthma
- ❑ Glaucoma
- ❑ Gynecological Problems
- ❑ Loss Of Hearing
- ❑ Liver Disease / Hepatitis
- ❑ Cancer
- ❑ Thyroid Disease
- ❑ Osteoporosis
- ❑ Bleeding Disorder
- ❑ Hay Fever
- ❑ Kidney / Bladder Disease
- ❑ Emphysema
- ❑ Eczema
- ❑ Peptic Ulcer
- ❑ Heart Problems
- ❑ Seizures
- ❑ Arthritis
- ❑ Anemia
- ❑ Depression
- ❑ Anxiety
- ❑ Cataracts