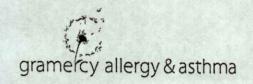
## **REGISTRATION FORM**

## Jennifer Collins, MD Allergy, Asthma, Immunology

Full name:	SS #:			
Address:				
Street	Apt#	City		Zip
Cell #:	_ Home #:	Wor	k#:	
Sex: DM DF Date of Birth:	Age:	□ Single □	Married  Wid	lowed   Divorced
E-mail:		Join our e	-mail list?	es 🗆 No
Primary Care Doctor.	Phone	#:	Fax #:	<b>基金属的</b>
Address:				
Street	Floor/Suite	City	State	Zip
Referred by: 🗆 Dr		Friend   Interne	t 🗆 Insurance	
Employer:	Occ	upation:		
Address:Street		City	State	Zip
			State	2.19
Dalaman V	INSURANCE INFO			
Primary Insurance:				
Secondary Insurance:	Policy/M	ember ID #:		
Relationship to Subscriber:	REFEI	RRAL REQUIR	ED? 🗆 Yes	□ No
Subscriber's SS#:	Birth Date:	Pho	ne #:	
	PHARMACY INFO	DRMATION		
Pharmacy Name:			Fax #:	
Address:				
Street		City	State	Zip
Emergency Contact:	Relationship	to patient:	Phon	e #;
I/We do hereby consent to and a physician and staff of Gramercy guardian. I hereby co	uthorize the performance of all y Allergy & Asthma to me or the ertify that, to the best of my kn	e above-named m	ninor of whom I ar	n the parent or legal
Patient/Guardian Signa	sture	Printed Name		Date

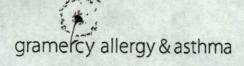


Jennifer Collins, MD

Board Certified Internal Medicine
Board Certified Allergy, Asthma & Immunology, Adult & Pediatric

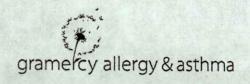
We want to make sure you are feeling well. In the past 6 months, have you experienced any of the following?

□ Fever/ chills □ Weakness □ Trouble sleeping □ Snoring	Respiratory: □ Cough □ Sputum □ Coughing blood □ Shortness of breath □ Wheezing □ Painful breathing
Skin: □Rashes □ Lumps □ Itching □ Dryness □ Reactions to makeups/lotions? □ Hair and nail changes	Cardiovascular: □ Chest pain/discomfort □ Tightness □ Palpitations □ Shortness of breat with activity □ Difficulty breathing lying down □ Swelling □ Sudden awakening from sleep with
Head: □ Headache □ Pain/Pressure in Ears □ Decreased hearing □ Ringing in Ears	shortness of breath
□Earache □ Drainage	Gastrointestinal: □ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea
Eyes: □ Vision Loss/Changes □ Glasses or contacts □ Pain □ Redness □ Blurry/Double vision □ Glaucoma □ Cataracts	☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Yellow eyes/skin
Last eye exam?/	Urinary: ☐ Frequency ☐ Urgency
Name Office Co.	☐ Burning/pain ☐ Blood in urine
Nose: □ Stuffiness □ Discharge □ Itching □ Hay Fever □ Nosebleeds □ Sinus pain	☐ Incontinence ☐ Change in urinary strength
☐ Hx of nasal trauma	Musculoskeletal:   Muscle/joint pain
	☐ Stiffness ☐ Back pain ☐ Redness of joints
Throat: □ Bleeding □ Dentures □ Sore tongue □ Dry mouth □ Sore throat □ Hoarseness	Swelling of joints
☐ Thrush ☐ Non-healing sores	Psychological: □Feelings of sadness, frequent crying/feeling blue □ Anxiety
Neck:□ Lumps □ Swollen Glands □ Pain	
□Stiffness	Neurologic: □ Dizziness □ Fainting
Breasts: □Lumps □Pain □Discharge	Hematologic: □Ease of bruising
□ Self-exam	□ Ease of bleeding
Are you breast feeding or planning pregnancy?	
□Yes □No	Endocrine: □ Change in sex drive?
Halaka A .	☐ Head/cold intolerance ☐ Sweating
Height: ft in.	□ Frequent urination □ Thirst
Weight: lbs.	□ Change in appetite
Any known allergies? Please list:	Patient Signature
	Date:/
Do you take any medications? Please list:	Reviewed with



On November 20, 2000 President William Clinton enacted "Patient Privacy Regulations". As regulations cover most aspects of how physicians relate to each other, hospitals, insurers & employers, Gramercy Allergy & Immunology wants to protect your rights.

We need your written permission to indicate your wishes in or "No" to indicate your choice	each of the following areas. Please check "Y
Gramercy Allergy & Immunology may release verbally or in w required to prescribe medications or obtain authorization from	
YES [	NO 🗌
Gramercy Allergy & Immunology may release verbally or in w of performing laboratory test of other tests, admitting you to the	writing medical information to your insurer as pa e hospital or providing medical care.
YES 🗌	NO 🗌
Gramercy Allergy & Immunology may release verbally or in warelease includes: 1) Release to return to work, 2) Insurance for compensation, and 3) Letters indicating medical reasons for domissed days of work.	rms related to medical coverage or workers'
YES 🗀	NO 🗌
Gramercy Allergy & Immunology may discuss my medical coinvolved in my care.	ndition with other physicians involved or to be
YES _	NO 🗌
1 m = 1 m =	
PATIENT NOTIFICATION RECORD	
I consent to share my health information for payment & treatm	ent.
I acknowledge I have been given the following notices as requ	ired by State and Federal regulations:
HIPPA Form     Notice of Privacy Policy	
Signature (Patient/Authorized Representative)	Printed Name Date



## Cancellation/No Show Agreement

In order to better serve our patients, Gramercy Allergy & Asthma has implemented a 24 hour Cancellation & No Show Policy. This policy applies to NEW and FOLLOW-UP appointments and excludes allergy shot appointments. Please contact our office 24 hours in advance if you need to cancel or reschedule your appointment to avoid being charged a no-show fee of \$30.00. I understand this fee is not covered by my insurance and is non-refundable.

## Agreement of Responsibility

I understand that Gramercy Allergy & Asthma is responsible for collecting any outstanding cost-sharing amounts (deductible, co-insurance, copayments) directly from patients. I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. In addition, I understand I am financially responsible if there is a lapse in my insurance coverage or if a referral from my primary care physician is missing and is required by my insurance company. I understand I will receive a monthly statement for any balance due by me.

By providing my payment information, I authorize Gramercy Allergy & Asthma to assess cancellations, no-show fees, balances, and medical services not covered by my insurance company according to the above outlined policies. I understand that all due balances will be discussed with me prior to being applied to the credit card, including the option of arranging a payment plan for large balances. Name as appears on card: Credit Card information: ☐ MasterCard □ Visa ☐ Discover ☐ American Express Please check (if applies): □ HSA □ HRA □ FSA Card Number: Expiration Date: / Signature (Patient or responsible financial party) Printed Name Date

Thank you in advance for your cooperation in helping us provide the best care possible for all of our patients at *Gramercy Allergy & Asthma*.