REGISTRATION FORM
Jennifer Collins, MD
Allergy, Asthma, Immunology

Full name: ______________________________ SS #: ____________________

Address: ____
Street | Apt # | City | State | Zip

Cell #: ______________ Home #: ______________ Work #: ______________

Sex: ☐ M ☐ F Date of Birth: ____________ Age: ______ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

E-mail: ______________________________ Join our e-mail list? ☐ Yes ☐ No

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Primary Care Doctor: ______________ Phone #: ______________ Fax #: ______________

Address: ____
Street | Floor/Suite | City | State | Zip

Referred by: ☐ Dr. ______________ ☐ Family ☐ Friend ☐ Internet ☐ Insurance

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Employer: ______________________ Occupation: ______________________

Address: ____
Street | City | State | Zip

INSURANCE INFORMATION

Primary Insurance: ______________ Policy/Member ID #: ______________

Secondary Insurance: ______________ Policy/Member ID #: ______________

Relationship to Subscriber: ______________ **REFERRAL REQUIRED? ☐ Yes ☐ No**

Subscriber's SS#: ______________ Birth Date: ______________ Phone #: ______________

PHARMACY INFORMATION

Pharmacy Name: ______________ Phone #: ______________ Fax #: ______________

Address: ____
Street | City | State | Zip

Emergency Contact: ______________ Relationship to patient: ______________ Phone #: ______________

I/We do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the physician and staff of Gramercy Allergy & Asthma to me or the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all of the above information is true.

______________________ ______________________ ______________
Patient/Guardian Signature | Printed Name | Date

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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?

General: ☐ Weight loss or gain ☐ Fatigue ☐ Fever/ chills ☐ Weakness ☐ Trouble sleeping ☐ Snoring

Skin: ☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness ☐ Reactions to makeups/lotions? ☐ Hair and nail changes

Head: ☐ Headache ☐ Pain/Pressure in Ears ☐ Decreased hearing ☐ Ringing in Ears ☐ Earache ☐ Drainage

Eyes: ☐ Vision Loss/Changes ☐ Glasses or contacts ☐ Pain ☐ Redness ☐ Blurry/Double vision ☐ Glaucoma ☐ Cataracts
Last eye exam? ______/______/______

Nose: ☐ Stuffiness ☐ Discharge ☐ Itching ☐ Hay Fever ☐ Nosebleeds ☐ Sinus pain ☐ Hx of nasal trauma

Throat: ☐ Bleeding ☐ Dentures ☐ Sore tongue ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush ☐ Non-healing sores

Neck: ☐ Lumps ☐ Swollen Glands ☐ Pain ☐ Stiffness

Breasts: ☐ Lumps ☐ Pain ☐ Discharge ☐ Self-exam
Are you breast feeding or planning pregnancy?
☐ Yes ☐ No

Height: ____ ft. _____ in.
Weight: ______ lbs.

Any known allergies? Please list:

Do you take any medications? Please list:

Respiratory: ☐ Cough ☐ Sputum ☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing ☐ Painful breathing

Cardiovascular: ☐ Chest pain/discomfort ☐ Tightness ☐ Palpitations ☐ Shortness of breath with activity ☐ Difficulty breathing lying down ☐ Swelling ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal: ☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Yellow eyes/skin

Urinary: ☐ Frequency ☐ Urgency ☐ Burning/pain ☐ Blood in urine ☐ Incontinence ☐ Change in urinary strength

Musculoskeletal: ☐ Muscle/joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints

Psychological: ☐ Feelings of sadness, frequent crying/feeling blue ☐ Anxiety

Neurologic: ☐ Dizziness ☐ Fainting

Hematologic: ☐ Ease of bruising ☐ Ease of bleeding

Endocrine: ☐ Change in sex drive? ☐ Head/cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst ☐ Change in appetite

Patient Signature ________________

Date: _____/_____/______

Reviewed with____________________

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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 each of the following areas. Please check "Yes" or "No" to indicate your choice

Gramercy Allergy & Immunology may release verbally or in writing medical information to a pharmacy as required to prescribe medications or obtain authorization from your insurer.

YES ☐ **NO** ☐

Gramercy Allergy & Immunology may release verbally or in writing medical information to your insurer as part of performing laboratory test of other tests, admitting you to the hospital or providing medical care.

YES ☐ **NO** ☐

Gramercy Allergy & Immunology may release verbally or in writing medical information to my employer. This release includes: 1) Release to return to work, 2) Insurance forms related to medical coverage or workers' compensation, and 3) Letters indicating medical reasons for doctors' appointments or other reasons leading to missed days of work.

YES ☐ **NO** ☐

Gramercy Allergy & Immunology may discuss my medical condition with other physicians involved or to be involved in my care.

YES ☐ **NO** ☐

PATIENT NOTIFICATION RECORD

I consent to share my health information for payment & treatment.

I acknowledge I have been given the following notices as required by State and Federal regulations:

1) HIPPA Form
2) Notice of Privacy Policy

Signature (Patient/Authorized Representative) ______ Printed Name ______ Date ______

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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.*