ALLERGY & ASTHMA SPECIALISTS

WILLIAM R. LUMRY, M.D. J. BRETT WEST, M.D.
BOARD CERTIFIED: AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

10100 NORTH CENTRAL EXPRESSWAY SUITE 100
DALLAS, TEXAS 75231

PHONE: (214) 373-7374 FAX (214) 373-7003

INFO@ALLERGYSPECIALISTS.US WWW.ALLERGYSPECIALISTS.US

Welcome to our practice! To make your first appointment as efficient and as useful to you as possible please complete the enclosed New Patient Registration Forms and Allergy Questionnaire prior to arriving. Please bring these forms along with any medical records pertinent to your medical condition with you to your appointment.

Please arrive 15 minutes prior to your scheduled appointment so that we may review this information and set up your chart. If you are seeing us for an asthma or a nasal allergy/sinus problem, please **stop any antihistamine containing allergy medications and other antihistamine containing medications** such as over the counter sleeping aids (Tylenol PM, Sominex, Unisom) and antidepressants (Elavil, Sinequan, Seroquel, Remeron) **three (3) full days before** your appointment so we can test your allergies if this is necessary. Please call if you have a question about your medications.

Please bring your insurance card and information and referral authorization from your regular physician if required by your health plan to your visit. If you are not sure if you need a preauthorization from your health plan, please check with your employee benefits manager, your insurance company or your regular doctor's office. We will need all of this information at the time of your appointment so that your insurance carrier can be properly billed and you can get maximum benefit from your medical insurance.

* *

The office is located at 10100 North Central Expressway in Suite 100. It is in a six story white stone and green/gray glass building located the northeast corner of La Sierra Drive and the North Central Expressway (Highway 75) northbound frontage road. The office entrances are on the east or west side of the building. Suite 100 is to the left as you enter the building from the front (west side). Parking is available along the front and back of the building as well as on adjacent streets.

La Sierra Drive is two blocks north of Walnut Hill Lane to the right off the North Central Expressway northbound frontage road. We are one long block west and one block north of the Walnut Hill and Manderville DART station and on Bus Route 502 at: US 75 - at - Blair stop.

Please refer to the map attached or the Google map link in the email. Call us if you have any questions.

If you have questions about directions or appointments, please call (214) 373-7374 for assistance. You do not need to mail, email or fax this information back to us, please bring it with you to your appointment with any pertinent medical records and xrays.

If for some reason you are not able to keep your appointment, please call 48 hours in advance so we can reschedule your visit and use your appointment time for another patient.

Thank you for your confidence in our practice. We look forward to helping you with your allergy or asthma-related problems.

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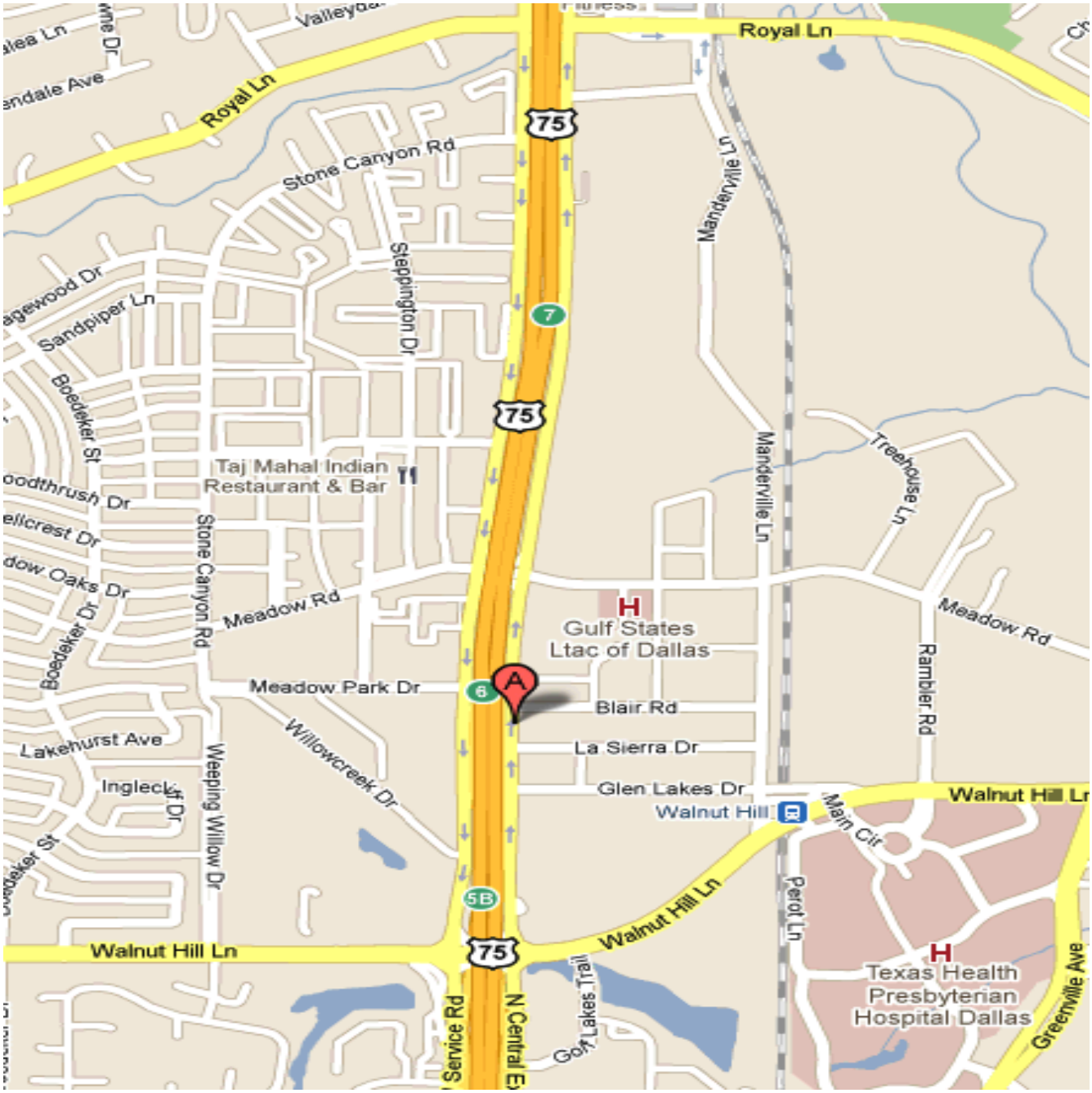
(214) 373-7374

The office is located on the northbound North Central Expressway (US Hwy 75) frontage road between La Sierra Drive and Blair Road. The building is white stone with silver/blue glass. Entry and parking are available in both the front and back of the building.



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William R. Lumry, M.D.
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Kimberly Poarch, PA-C

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Please print and fill in completely. If you need help, please ask the receptionist.

Date: _____ Patient ID Number: _____ (office use only)

Patient Last Name: _____ Patient First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (_____)_____ Sex: _____ Birth date: _____ Age: _____

Mobile Phone: (_____)_____ Email Address: _____

Social Security #: _____ Drivers License #: _____ State: _____

Marital Status: ____ Single ____ Married ____ Legally Separated ____ Divorced ____ Widowed ____ Other

Employer: _____ Work Phone: (_____)_____ Ext: _____

Name of Primary Insured, if other than Patient: _____Primary Insured's Birth date:_____

Primary Insured's Employer: _____

Address of Primary Insured: _____ City: _____ State:_____

Zip: _____ Phone: (_____)_____ Relationship of Primary Insured to Patient: _____

Nearest Relative Not Living with you: _____ Phone: (_____) _____

Please list other members of your family who are patients here and their relationships to you:

_____

Who may we thank for referring you to our office? (Please specify by name) Doctor:_____

Family:_____Friend: _____ Insurance Co.: _____

Phone Book/Internet: _____ Do you have Medicare or Medicaid medical insurance coverage? ____ yes ____ no

Is your medical insurance coverage with an HMO, PPO or other "managed health plan" option? ____ yes ____ no

* *

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of such claims and that all proceeds of insurance will be assigned to this office. I authorize the release of any medical information necessary to process an insurance claim and also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature on File: _____ Date: _____

IF PATIENT UNDER AGE 18: Drs. Lumry and staff have my permission to exam and treat _____

Signature of Parent or Guardian: _____ Witness: _____

Thank you for choosing our office for your health care needs. We look forward to serving you.

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New Patient Medical Information Survey

To aid us in assessing your problem, please complete all 4 pages of this questionaire as accurately as possible. **If a section is not applicable to your problem, please move to the next section.**

NAME _____ Date of Birth _____ DATE _____

Please describe in your own words which problems led you to seek this allergy evaluation?

_____

_____

_____

How long have you had this/these problem(s)? _____

Do you have any special goals other than "to get better"? _____

_____

Do you have any specific questions you want answered?

_____

_____

NOSE:

Do you have problems with nasal drainage? ..... no yes

If yes, is it:
thick thin clear yellow

Have you had sinus infections? ..... no yes

Do you have problems with nasal congestion?..... no yes

Do you sneeze? ..... no yes

If yes, do you sneeze:
rarely often continuously in attacks

EYES:

Do your eyes:
Itch? ..... no yes
Tear? ..... no yes
Swell? ..... no yes
Become red?..... no yes

If yes, does this occur in the:.....
morning afternoon evening night

Does your eyesight ever blur? ..... no yes

Have you ever had problems with double vision? ..... no yes

Do you ever have pain in or around your eyes?..... no yes

EARS:

Do you have problems with your ears? ..... no yes

If yes, do they:
pop ring itch hurt

Do you have frequent ear infections? ..... no yes

MOUTH AND THROAT:

Do you have itching of the roof of your mouth?..... no yes

Do you have itching in the back of your throat?..... no yes

Do you ever feel as if you have mucus at the back of your throat? ..... no yes

Do you have frequent sore throats? ..... no yes

If yes, do these occur in the:
morning afternoon evening night

HEAD:

Do you have frequent headaches? ..... no yes

If yes, are they:
behind your eyes? ..... no yes
under your eyes? ..... no yes
back of the neck? ..... no yes
side of your head? ..... no yes
associated with sinus blockage? ..... no yes

Are your headaches worse in the:
morning afternoon evening night

Do you have congestion in your head? ..... no yes

CHEST:

Do you experience:
Tightness? ..... no yes
Shortness of breath? ..... no yes
Pressure on chest?..... no yes

Do you wheeze with colds or bronchitis?..... no yes

If yes, is your wheezes .....
seasonal?..... no yes

If yes, which season(s)?.....
Spring Summer Fall Winter

Is your wheeze ever triggered by:
Physical exertion?..... no yes
Emotional upset?..... no yes
Laughter? ..... no yes
Aspirin?..... no yes

Have you ever been told that you have asthma? ..... no yes

Do you cough a lot? ..... no yes

If yes, do you cough up mucus?..... no yes
Color: _____

Is your cough associated with:
Exertion? ..... no yes
Wheezing?..... no yes
Loss of sleep?..... no yes
Shortness of breath? ..... no yes

SKIN:

Have you ever had:
Eczema? ..... no yes
Hives? ..... no yes
Rash? ..... no yes

If yes to any of the above, what parts of the body were affected?:
all over face neck scalp
front of elbows behind elbows
wrists legs behind knees

Have you ever had problems with:
Swelling of your skin?..... no yes
Itching of your skin? ..... no yes
Burning of your skin? ..... no yes

ENVIRONMENTAL:

Are your symptoms seasonal? ..... no
If yes, which season(s)? (circle)
spring summer fall winter

Are your symptoms worse:
Indoors?..... no yes
Outdoors?..... no yes
At work/school?..... no yes
In Dallas?..... no yes
Away from Dallas? ..... no yes
Around aerosol spray? ..... no yes
Around strong odors? ..... no yes
If yes, around: .....
paints?..... no yes
perfumes? ..... no yes
household cleaners? ..... no yes
In smoke-filled rooms? ..... no yes
Around animals?..... no yes
Around mowed grass? ..... no yes
Around dust? ..... no yes
Around flowers?. ..... no yes
Around trees? ..... no yes
Around bodies of water? ..... no yes
Around exhaust?..... no yes

How long have you lived in the Dallas area?
_____

Where did you live before moving to the Dallas area?
_____

How long have you lived in your present home?
_____

How old is your present home? _____

Is your air conditioning:
Central unit?..... no yes
Window unit?..... no yes

How often are the filters changed?_____

Do you use fans in your home?
(Include ceiling fans) ..... no yes

Do you have a humidifier?..... no yes
If yes:
Is it connected to the
heating unit? ..... no yes

List any workplace exposures that bother you:
_____

List your hobbies/sports/leisure activities:
_____
_____

Is your pillow filled with:
Foam? ..... no yes
Feathers? ..... no yes
Dacron? ..... no yes

How old is your pillow? _____

How many pillows do you sleep on? _____

Is your mattress:
Innerspring?..... no yes
Foam?..... no yes
Other:_____

How old is your mattress?_____

Is your pillow and/or mattress
covered in plastic? ..... no yes

Is your bedroom carpeted? .. .. no yes

How often do you vacuum?_____

Do you have plants in the house? ..... no yes
If yes:
How many? _____

Do you have any pets?..... no yes
If yes:
What kind? _____
How many?_____
Are they:
Inside?..... no yes
Outside?..... no yes
Both?..... no yes

Do or did you smoke?..... no yes
If yes:
Cigarettes?..... no yes
Pipe?..... no yes
Cigar? ..... no yes

How much do/did you smoke? _____

How many years have/did you smoked?_____

If you stopped, When? _____

Are there smokers in your home? ..... no yes

Do you have hobbies which cause or .....
aggravate your condition? ..... no yes

Do you exercise regularly?..... no yes
(3-4 times per week)

PREVIOUS EVALUATION/TREATMENT:

Have you had sinus x-rays?.....no yes
If yes, date: _____

Have you ever been skin tested?.....no yes
If yes, date: _____

Have you ever taken allergy..... shots?.....no yes
If yes:
Date started:_____
Date stopped:_____

Have you been told that you have:
Sinusitis? .....no yes
Polyps? .....no yes
Deviated septum? .....no yes

Have you ever been treated for:
Allergies?.....no yes
Hayfever?.....no yes
Asthma?.....no yes

Have you ever had a chest x-ray? .....no yes
If yes:
When:_____
Where:_____

MEDICAL HISTORY:

Do your symptoms keep you from performing:
At work at school?.....no yes
Daily activities?.....no yes

Are there any foods which you are sensitive to?.....no yes
_____
_____

Are you sensitive/allergic to any drugs?
If yes, please list:
Medicine Reaction
_____
_____
_____

Have you had a reaction to an insect.. sting?.....no yes
If yes, what insect?
_____

Circle type of reaction:

Swelling	Pain
Weakness	Shortness of
Sweating	breath
Wheezing	Stuffy nose
Redness	Throat closing

Have you ever been hospitalized or .. had surgery? .....no yes
If yes, please list:
_____
_____
_____
_____
_____
_____

Have you ever had an injury or ..... surgery of the nose?.....no yes
If yes, when, what, by whom?
_____

Please circle any of the following health problems you have had in the past and/or do have at the present time:
Stiff or painful joints.....no yes
High blood pressure .....no yes
Ulcers .....no yes
Tuberculosis .....no yes
Tonsillitis.....no yes
Nose bleeds.....no yes
Frequent influenza ("flu") .....no yes
Pneumonia .....no yes
Colic .....no yes
Serum reactions .....no yes
Difficulty urinating (men).....no yes

Are you being treated for any other medical problems?.....no yes
If yes, please list:
_____
_____
_____

Have you ever received medical treatment in an emergency room?.....no yes
If yes, please list why:
_____
_____

Do any family members suffer from:
Allergies?.....no yes
Hayfever?.....no yes
Asthma?.....no yes

List all medications you are presently taking. Include nose drops, eye,drops, inhalers, antihistamines, decongestants, aspirin/tylenol
Medicine: Last Taken:

_____

_____

_____

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Authorization for Release of Medical Records

To: _____

_____

_____

_____

Mail or **Fax** records to:

ALLERGY & ASTHMA SPECIALISTS
10100 N. Central Expressway
Suite 100
Dallas, TX 75231
Fax: (214) 373-7003

I, the undersigned, hereby authorize the above named individual or entity to release the following protected information for the purpose of review, evaluation and continuity of care from my medical record to Allergy & Asthma Specialists. This authorization includes the release of information concerning HIV testing or the treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.
The following information may be released/reviewed: **Note: Our office will select what is needed.**

- ☐ Initial History and Physical
- ☐ Outpatient Clinic Notes
- ☐ Consultation Reports
- ☐ Laboratory Test Results
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Culture Results
- ☐ Anesthesia Records
- ☐ Emergency Medical Department Record
- ☐ Discharge Summary
- ☐ Pulmonary Function Studies
- ☐ Radiology Studies
- ☐ _____
- ☐ Immunization Records
- ☐ Growth Charts
- ☐ All Skin Test/In-Vitro Allergy Studies (RAST, Immuno Cap, etc.)
- ☐ Exact Composition of CurrentAllergen Extract (**Please include specific antigens, concentration, volume and supplier**)

Patient Information Is Needed For: ____ Continuing Medical Care ____ Personal Use

____ Social Security/Disability Insurance ____ Military ____ Other: _____

Approximate period of care: _____ to _____.

Please restrict the above release to the following particular illness: _____. No Restriction: ☐

This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to the revocation. This consent will expire one hundred-eighty days (180) after the date below, or sooner by my choice, in which case this consent will expire on _____.
If I wish to revoke this consent prior to the period above, a request must be submitted in writing with a date of effect after the date of signature on this form.

Patient's Name:_____ Signature: _____

Address:_____ Relationship (if legal guardian):_____

_____ Birthdate (MM/DD/YYYY):____/____/_____

_____ Date: _____