

Office Use

F/C: INS _____ MC _____ SP _____ CFW# _____
 Included: Insurance Card Copy _____ Referral/Authorization _____

Patient Information

Thank you for choosing the Center For Wellbeing. In order to help us complete our records and submit accurate bills to your insurance company, please assist us by providing the following information:

First Name: _____ M.I.: _____ Last Name: _____
 Date of Birth: _____ Patient's SS #: _____ Sex: _____
 Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 Home #: _____ Cell#: _____ Work#: _____
 Email: _____ Employer: _____
 Referred By: _____
 PCP Name: _____ Phone #: _____

Insurance Information

Please fill out this section entirely.

Primary Insurance

Relationship to Insured:	Self: _____ Spouse: _____ Child: _____ Other: _____
Insured's Name:	_____
Insured's Date of Birth:	_____
Insured's ID#:	_____
Insured's Employer:	_____

Secondary Insurance

Relationship to Insured:	Self: _____ Spouse: _____ Child: _____ Other: _____
Insured's Name:	_____
Insured's Date of Birth:	_____
Insured's ID#:	_____
Insured's Employer:	_____

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges; which may also include legal, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate provider and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of doctor services. I understand that for any balance remaining on my account past 30 days, pursuant to Center for Wellbeing's discretion, my account may be turned over to collections or there will be a monthly late fee assessed of \$15 for up to 3 months, and after that time my account may be turned over to collections.

Patient Signature : _____ Date : _____



Check **ALL medical conditions** that you may have had or currently have now:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Eczema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Raynaud's |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Vertigo/Dizziness | | |

Other: _____

Please list all previous surgeries & dates:

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially

Tobacco use? Yes / Never / Former Smoker PPD _____ How many years? _____



CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment, you provide a 24-hour notice. Appointments which are cancelled within less than 24-hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no-show fees can be directed to the front desk at (603) 380-9159.

Please sign that you have read, understand, and agree to this cancellation and no-show policy.

Patient Name (Please Print)

Date

Signature of Patient

Date



AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes _____ No _____

I fully understand that my signature is consent and authorization to be examined by the Center for Wellbeing medical team.

Patient Signature _____ Date _____

Authorization to Disclose Medical Records and Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Records Release To:

Provider/Clinic/Organization: _____ CENTER FOR WELLBEING

Bedford: 18 Constitution Dr. Suite 2, Bedford, NH 03110 Phone: 603-472-6192 Fax: 603-472-6196

Portsmouth: 3201 Lafayette Rd., Portsmouth, NH 03801 Phone: 603-380-9159 Fax: 603-427-8290

I hereby authorize the release of my medical records to the provider designated above.

Please Initial

_____ Complete Medical Record

Patient Signature: _____ **Date:** _____

INITIAL ALLERGY EVALUATION

Patient Name: _____

Patient Number: _____ Date: _____

PATIENT HISTORY

	<u>YES</u>	<u>NO</u>
Do you have symptoms, or have you ever had symptoms, such as sneezing, watery nasal discharge, throat itching or dry mouth?	_____	_____
Do you have, or have you ever had, frequent “colds”, sinus problems or chronic nasal congestion?	_____	_____
Do you have, or have you ever had, your eyes itch, water, get red or swell?	_____	_____
Are your symptoms seasonal only, or do they get worse in certain seasons?	_____	_____
Are your symptoms worse around animals?	_____	_____
Do you have, or have you ever had asthma, eczema or hives?	_____	_____
Do you have sensitivities to foods?	_____	_____

FOR PHYSICIANS USE ONLY

ORDER FOR ALLERGY TESTING AND TREATMENT IF INDICATED

___ 95004 TESTING ___ Blood Spot Testing IgE (laboratory will bill patient insurance)

___ 95165 TREATMENT

ICD - 10 DIAGNOSIS CODE: J30.1 ALLERGIC RHINITIS DUE TO POLLEN J30.5 ALLERGIC RHINITIS DUE TO FOODS

PHYSICIAN SIGNATURE

Negative Screening

Screening Appropriate refer to allergy program

Patient Declines



ASTHMA, ALLERGY AND IMMUNOLOGY REVIEW

Patient Name: _____ Age: _____ Occupation: _____
 Date of Birth: _____ Today's Date: _____ Physician that referred you (If any): _____

Please answer all questions on both pages to the best of your ability. Base your answers on your own observations and not what you have been told by others or what you may have presumed based on previous allergy tests. Complete the questionnaire before you see the Physician as the information will organize your thinking and facilitate understanding of your case.

I. Describe in your own words your problem(s) which might indicate an allergic or exaggerated reaction:

II. Add an X in the blanks that apply to your symptoms:

EYE SYMPTOMS (Do you wear contacts? _____)

	<u>Present Problem</u>	<u>Past Problem</u>	<u>Physician Comments</u>
Itching	_____	_____	_____
Watering	_____	_____	_____
Redness	_____	_____	_____
Swelling	_____	_____	_____
Burning	_____	_____	_____
Dryness	_____	_____	_____
Foreign Body Sensation	_____	_____	_____

SYMPTOMS IN THE UPPER RESPIRATORY TRACT (NOSE, SINUSES, THROAT, EUSTACHIAN TUBES, VOICE BOX)

	<u>Present Problem</u>	<u>Past Problem</u>	<u>Physician Comments</u>
Itching	_____	_____	_____
Sneezing	_____	_____	_____
Congestion	_____	_____	_____
Headache	_____	_____	_____
Obstruction	_____	_____	_____
Drainage	_____	_____	_____
Dryness	_____	_____	_____
Hoarseness	_____	_____	_____
Hearing Loss	_____	_____	_____
Polyps	_____	_____	_____
Impaired Smell/Taste	_____	_____	_____
Snoring	_____	_____	_____

ASTHMA, ALLERGY AND IMMUNOLOGY REVIEW (Cont.)

SYMPTOMS IN THE LOWER RESPIRATORY TRACT (WINDPIPE, BRONCHI, LUNGS)

	<u>Present Problem</u>	<u>Past Problem</u>	<u>Physician Comments</u>
Itching	_____	_____	_____
Coughing	_____	_____	_____
Sputum Production	_____	_____	_____
Tightness - Congestion	_____	_____	_____
Wheezing	_____	_____	_____
Shortness of Breath	_____	_____	_____

III. Place an X in the blanks that are Aggravated or precipitated by Exposure or during:

	<u>Eyes</u>	<u>Nose/Ears/ Sinuses</u>	<u>Chest</u>	<u>Hives/ Digestive</u>	<u>Swelling</u>	<u>Eczema</u>
Spring (Mar, Apr, May)	_____	_____	_____	_____	_____	_____
Summer (Jun, Jul, Aug)	_____	_____	_____	_____	_____	_____
Autumn (Sep, Oct, Nov)	_____	_____	_____	_____	_____	_____
Winter (Dec, Jan, Feb)	_____	_____	_____	_____	_____	_____
Sleep	_____	_____	_____	_____	_____	_____
On awakening	_____	_____	_____	_____	_____	_____
At work	_____	_____	_____	_____	_____	_____
At play	_____	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____	_____
Emotional upset – laughter, anger	_____	_____	_____	_____	_____	_____
Weather changes	_____	_____	_____	_____	_____	_____
Heat	_____	_____	_____	_____	_____	_____
Cold	_____	_____	_____	_____	_____	_____
Air conditioning	_____	_____	_____	_____	_____	_____
Sunlight	_____	_____	_____	_____	_____	_____
Irritant fumes/aerosols/sprays	_____	_____	_____	_____	_____	_____
Smog	_____	_____	_____	_____	_____	_____
Cosmetics/perfumes	_____	_____	_____	_____	_____	_____
Tobacco smoke	_____	_____	_____	_____	_____	_____
Newsprint	_____	_____	_____	_____	_____	_____
House Dust	_____	_____	_____	_____	_____	_____
Road Dust	_____	_____	_____	_____	_____	_____
Cats	_____	_____	_____	_____	_____	_____

IV. Place an X in the blanks that are Aggravated or precipitated by Exposure or during:

	<u>Eyes</u>	<u>Nose/Ears/ Sinuses</u>	<u>Chest</u>	<u>Hives/ Digestive</u>	<u>Swelling</u>	<u>Eczema</u>
Dogs	_____	_____	_____	_____	_____	_____
Birds/Feathers	_____	_____	_____	_____	_____	_____
Other animals: _____	_____	_____	_____	_____	_____	_____
Egg	_____	_____	_____	_____	_____	_____
Milk / dairy products	_____	_____	_____	_____	_____	_____
Wheat / wheat products	_____	_____	_____	_____	_____	_____
Corn / Corn products	_____	_____	_____	_____	_____	_____
Strawberries / other berries	_____	_____	_____	_____	_____	_____
Peanut / other nut	_____	_____	_____	_____	_____	_____
Shrimp /lobster / other seafood	_____	_____	_____	_____	_____	_____
Beer/Wine	_____	_____	_____	_____	_____	_____
Chocolate	_____	_____	_____	_____	_____	_____
Other food(s) _____	_____	_____	_____	_____	_____	_____

Provider Signature _____

Date: _____