DAVID T. PLAXICO, M.D.
Allergy & Asthma Clinic of Macon

Date _____

Family Dr._____ Dr. Address _____
Full Name _____
Did your doctor refer you? Yes___ No___
If no, by whom were you referred _____

Pharmacy name and phone number_____

Patient Info (please print)

_____ _____
Legal Last Name First Name Initial Home Phone #

_____
Legal Home Address
_____
Mailing Address (if different from above)
City_____ State_____ Zip Code_____

Sex M___ F___ Race _____ Social Security #_____
Date of Birth _____ Age_____ Marital Status S M D W (circle one)

_____ Name (Patient or Mother if patient is a child)

_____
Employer Employer Address Work Phone #

_____ Name (Spouse or Father if patient is a child)

_____
Employer Employer Address Work Phone #

Are you a previous patient of Dr. Plaxico's _____ Yes _____ No
Other Family Members Under Dr. Plaxico's Care:_____
Nearest Friend or Relative not living with you:_____
Name Phone #

Insurance Information

Primary Insurance: Name of Ins. Company_____
Insured's Name _____DOB_____
ID #_____Group #_____ SS #_____

Secondary Insurance Information: Name of Ins. Company_____
Insured's Name_____ DOB_____
ID #_____Group #_____SS#_____

*****PLEASE SIGN ON BACK*****

PATIENT NAME:_____

PATIENT PAYMENT POLICY

Cash Patients

Patient has no insurance or has insurance which excludes allergies.

All visits are due in full at the time of service. Acceptable forms of payment are checks, cash, and major credit cards. I have been advised of the costs of this evaluation and am aware that I will have to pay in full today.

Signature_____Date_____SS#_____

Insurance Patients and Medicare

Insurance will be filed by this office as a courtesy to the patient. If you are insured through any plans which Dr. Plaxico participates, you will be required to pay any deductible not previously med (confirmed) and co-pays. I am aware that all balances are due in full within 90 days of date of service. Insurance will be filed but I understand that I am responsible for this bill. Acceptable forms of payment are checks, cash, and major credit cards. I authorize the release of any medical information necessary to process the claims submitted by Dr. Plaxico. I also authorize payment of medical benefits to Dr. Plaxico for services described on health insurance claim forms and acknowledge responsibility for any non-covered expenses and balances due.

Signature_____Date_____SS#_____

Medicare Lifetime Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for this or a related medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Signature_____Date_____SS#_____

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ DATE_____

Patient or Patient's Personal Representative

Dr. David T. Plaxico
Allergy & Asthma Clinic of Macon

Instructions: Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate answers to your **own** experiences, not to previous advice on skin tests. This form must be completed prior to seeing the physician. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.

Name Street City State ZIP

Age Sex Race Occupation Second Job Telephone

Name and address of referring physician:_____

State problem(s) you wish to discuss:_____
_____
_____

_____

When did it begin?_____(Year) How often does it occur?_____ (times per day, week, etc)

Worse at night or day?_____ How long does it last?_____ (hours, days, etc.)

Circle months most severe: January February March April May June July August
September October November December ALL YEAR

What do you think makes it better?_____

What do you think makes it worse?_____

What do you think causes the problem?_____
_____

Circle Terms Which Affect Your Problem:

Irritants: cleanser, detergent, cooking odor, perfume, powder, tobacco smoke, other smoke:_____, moth balls, motor fumes, paint lacquer, wax, glue, insect spray, fertilizers, ammonia, room deodorants, chemicals, Clorox, other:_____

Toiletries: soap, shampoo, shaving cream, after shave, spray deodorant, hair spray, hair tonic, hair dye, hand cream, make-up, toothpaste, denture cream, mouthwash, nail polish, other:_____

Foods: milk, cheese, eggs, fish, shellfish, nuts, chocolate, alcohol, wine, beer, juices, spices, vegetables, strawberries, wheat products, very cold liquids, other:_____

Pets: Which of these do you have as pets: dog, cat, bird, horse, hamster, rabbit, other:_____

Is your condition worse around pets?__ (Specify):_____

Drugs: Penicillin, Sulfa, Aspirin, Over-the-counter drugs, other:

_____

Weather: hot, cold, humid, damp, pollution, smog, sunlight, air-conditioning, change in temperature

New Clothing: (unwashed) wool, silk, sweater, coat, shoes, dry-cleaned clothes, starched clothes, other:_____

Contactants: poison ivy, cut grass, cut flowers, household plants, hay, Christmas trees, plastic, fiberglass, rubber, dust, wool blankets, feather pillows, mattress, overstuffed furniture, rugs, rug pads, stuffed toys, furs, jewelry, shoe polish, other:_____

Circle Symptoms Brought On By Your Problem:

General: nervousness, dizziness, fainting, sinus trouble, frequent colds, fatigue, other:_____

Headache: Where (front, back, right, left), day, night, aching, throbbing, sharp, dull, with vomiting, stuffy nose, better with sleep, worse with tension, spots before eyes. CAUSE: migraine, food, sinus, tesion, drug, other:_____

Skin: rash, hives, eczema, blisters, itching, swelling, burning, stinging, redness, perspiration, dandruff, athlete's foot
Where:_____. Worse after eating? Yes/No

Eyes: tearing, burning, itching, pain, redness, discharge, puffiness, infections, blurring of vision, glaucoma, other:_____

Ears: pressure, itchiness, drainage, bleeding, infections, deafness, swelling, other:_____

Nose: trouble smelling, stuffiness, sniffles, itching, sneezing, snoring, polyps, post-nasal drip, picking, bleeding, broken nose, previous surgery, other:_____

Tongue: swollen, sore, itching, coated, trouble tasting, other:_____

Mouth: itching of roof, repeated tonsillitis, tonsils removed, morning sore throats, bad breath, swollen lip, trouble swallowing, mouth breathing, frequent throat clearing, change in voice, other:_____

Mucus: thick, thin, clear, yellow, green, brown, bloody, amount per day: teaspoon, tablespoon, ½ cup, source of mucus: nose, lungs, throat

Chest: shortness of breath, wheeze, pain, tightness, cough, cough then wheeze, trouble walking, trouble working, trouble sleeping, heart trouble, high blood pressure, emphysema, bronchitis, pneumonia, tuberculosis, cancer, asthma, other:_____

Stomach: vomiting, gas, cramps, belching, diarrhea, mucus in stool, blood in stool, foul-smelling stool.
soiling: worse after eating what foods:_____,
other:_____

Joints: pain, stiffness, swelling, other:_____

Menses: (Female Only): regular, irregular, discharge, itch, cramps, infections, last period:_____(date), pain. Are you now pregnant? Yes/No. Taking birth control pills? Yes/No

Urine: pain, burning, frequent urination, bladder infection, recurrent infection, itching, chills, fever, other:_____

Circle Pertinent Items And Fill In The Blanks:

1. **Where do you live?:** room, apartment, brick house, wood-frame house, mobile home, age of house:_____(years)

2. **Location:** city, suburbs, country, farm, seashore, desert, mountains, near factory, bakery, grain storage, swamp, poultry yard, barn, other:

_____

3. **Problem worse in:** bedroom, living room, kitchen. basement, attic, garage, indoors, outdoors, other:_____

4. **Type of heating:** forced air, radiator, electric, heat pump, filtered air, other:

_____

5. **In what state or geographical areas is it worse?** _____

_____

6. **Problem worse when:** at home, at work, in car, in boat, exercising, at beauty shop, at school, driving in traffic, sweeping, house cleaning, making beds, around fans, around humidifier, around vaporizer, around open windows, around heating ducts, on windy days, taking hot or cold baths, swimming in chlorinated water, in musty places, wearing tight clothing, other:_____

_____

7. **Insect bites or stings:** more than average, large swelling, weakness, sweating, shortness of breath, stuffy nose, wheezing, other:

_____

8. **Recent dental work:** fillings, caps, root canal, tooth extraction, braces, novocaine, cleaning, gum surgery, pyorrhea, bridge, denture, other: _____

9. **Marital status:** (Parents' status if patient is a child) married, single, separated, divorced, widowed

   Number of children: 1, 2, 3, 4, 5, more

10. **Education:** grade school (highest grade): _____, high school (1, 2, 3, 4), college (1, 2, 3, 4), other:_____

11. **Smoking habits:** (circle): cigarettes, cigars, pipe, inhale? Yes/No. Number per day:_____ How long?_____(years)

12. **Medications Now Used:** **Times Used Per Day:**

13. **Drugs:** Marijuana, Heroin, other:_____

14. **Childhood:** breast fed, bottle fed, colic, spitting up, gas, croup, hives, eczema, hay fever, frequent colds, migraine, sinus trouble, earaches, tonsillitis, dizziness asthma, bronchitis, pleurisy, pneumonia, other:_____

15. **Immunizations:** (Circle any you have ever had & describe any reaction you had to the shot.)

Shot:	**Reaction:**	**Shot:**	**Reaction:**
Diphtheria:		Measles:	
Tetanus:		German Measles:	
Whooping Cough:		Mumps:	
Polio:		Influenza:	
Smallpox:		Other:	

16. **How would you describe yourself?** timid, quiet, aggressive, forward, shy, unfriendly, extrovert, depressed, tense, calm, relaxed, many friends, anxious, dependent, introvert, few friends, independent, bustling, happy, well-adjusted, other:

17. **Place age of family member having any of the following conditions in the appropriate box:**

Family Illnesses	Father	Mother	Brothers	Sisters	Children	Other Blood Relative
Migraine						
Hives						
Emphysema						
Asthma						
Cystic Fibrosis						
Eczema						
Hay Fever						
Tuberculosis						
Thyroid Disease						
Glaucoma						
Sinus						
Other						

18. **Hobbies:** **Husband:** **Wife:** **Children:** **Others At Home:**

19. **Seriousness of problem has caused** absence from work, absence from school, inability to sleep, inability to exercise, loss of appetite, nervousness, other:

20. **Unusual activities engaged in just prior to onset of symptoms:**

21. **Unusual food or drink just prior to onset of symptoms:**

22. **New environmental factors at home or at work:**

23. **Emotional factors:** tension, worry, trouble sleeping, financial problems, martial problems, family problems, problems at work, fatigue, cry easily, depression, sexual problems, other:_____

Do any of the above affect your problem? Yes / No
Explain:_____

24.List any medical condition(s) for which you have been treated:

25.**List any operations you have had:**_____

26.**List any other conditions for which you are currently being evaluated or treated:**_____

PHYSICIAN'S ANALYSIS OF DATA:

_____ _____ _____

Patient's Signature Physician's Signature Date