Daniel Suez, M.D., Allergy, Asthma & Immunology Clinic, P.A.

FAAAAI, Board Certified in Allergy & Immunology and Diagnostic Laboratory Immunology

Please fill in all relevant information, save file in a PDF format, print and sign all requested forms. Send in scanned signed forms via e-mail. If you are not able to scan signed printed forms, bring them with you.

New Patient Information Sheet

New Patient Information

Patient Last Name	First Name	MI	Age	Date of Birth	Social Security	Marital Status	Sex
			Yrs			M S D	M F
Home Address:					Home Phone #:		
City, ST, Zip:					Cell Phone #:		
Email Address:							
Referring Physician Name and Address:							
Source of Referral if not by Physician:							

Person Responsible For Payment

Last Name	First Name	MI	Age	Date of Birth	Social Security	Relationship to Patient
			Yrs			
Home Address:					Hm Phone #:	
City, ST, Zip:					Cell Phone #:	
Employer:						
Employer Adddress:				City, ST, Zip:		

Other than the responsible party, In case of emergency contact:

Last Name	First Name	Relation to Patient	Hm Phone #:
			Bus Phone #:

Health Insurance Information – Primary Insurance

Insurance Name:	Insurance Address:
Member ID #:	
Group #:	City, ST, Zip:
Medicaid ID #:	Medicare ID #:

Health Insurance Information – Secondary Insurance	**Pharmacy Insurance**
Insurance Name:	Insurance Name:
Member ID #:	Member ID #:
Group #:	RX BIN:
Insurance Address:	RX PCN:
	RX Group:
City, ST, Zip:	

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangments have been made in advance.
I hereby authorize Dr. Daniel Suez to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Dr. Daniel Suez all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Signature ______________________________ Date ________________________

Patient Consent for Disclosure of Health Information

The patient has the right to review our privacy practices, which are available at the front desk of our clinic, or available upon request. In addition the patient has the right to request how many times their health information has been disclosed and to whom. **Daniel Suez MD** requires patient written consent before releasing protected health information.

With the patient's consent **Daniel Suez MD** may inform the patient at his home or any other designated location about patient statements, reminders, or other issues regarding patient care, including laboratory results. **Daniel Suez MD** may also inform my insurance carrier about the care received at the clinic for billing purposes only.

This consent may be changed by the patient in writing; however, this change would not affect prior authorizations. If the patient fails to sign this consent, **Daniel Suez MD** may decline treatment.

____________________________________ ______________________________

Signature of Patient or Legal Guardian Date

____

Patient's Name

____

Print Name of Patient or Legal Guardian

OFFICE POLICIES

Please read the following information regarding our office policies. After you have read the information, please sign and return it to the receptionist who will then give you a copy.

PAYMENTS/FEES

All co-pays and balances are due at the time of service. As a courtesy we will bill primary and secondary insurance. Notify the office of any insurance changes as soon as possible. If not notified, you will be responsible for the fee. **Note: There is a $25.00 retured check fee.** Phone consultation fee will be applicable.

PHONE AND CALLING AFTER HOURS

If you have an emergency or need to talk to the Doctor after our office hours, call our number (972-401-0545) and press ”0”. This will connect you with our answering service. The Doctor will be paged.

APPOINTMENTS

The receptionist will assist you with making an appointment at either of our facilities. If you have to reschedule or cancel an appointment, please do so as soon as possible. If not cancelled or rescheduled within 24 hours, **there is a $35.00 cancellation fee.**

REFERRALS

If your insurance plan requires a referral from your Primary Care Provide (PCP) it is the patient’s responsibility to obtain this before your visit. Your insurance will not pay without this referral and payment will be your responsibility. If you do not have your referral or our office has not received it, you will have to reschedule.

OFFICE HOURS

*Our office is closed from 12:00 – 1:30 for lunch.

Monday & Wednesday: 7:00-4:30
Tuesday & Thursday: 7:00-6:00
Friday: 7:00-12:30

____ ____________________________________

Patient/Guardian Signature Date

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PATIENT AUTHORIZATION FOR MEDICAL DISCLOSURE OVER THE TELEPHONE AND FAX

The Patient authorizes Daniel Suez MD to disclose medical information regarding clinical care and diagnosis including lab results and medical history to those listed below.

Name: ______________________________
Tel # ______________________________
Relationship: ______________________________

Name: ______________________________
Tel # ______________________________
Relationship: ______________________________

Name: ______________________________
Tel # ______________________________
Relationship: ______________________________

Name: ______________________________
Tel # ______________________________
Relationship: ______________________________

Name: ______________________________
Tel # ______________________________
Relationship: ______________________________

This consent is in effect until revoked in writing. Our office requires patient consent in writing for all information requests not related to billing requirements.

____
Name of Patient

______________________________ ______________________ ______________________
Signature of Patient or Legal Guardian | Relationship to Patient | Date

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Patient Questionnaire

Please answer the following questions as accurately as possible. This will assist the physician in being best prepared for you on the day of visit.

Last Name: ______________________ First Name: ________________ Age: ___Years DOB: _________

Person completing this questionnaire (Name): ____
Relationship to Patient:____
Referring Physician (Name) and Specialty: ____
(i.e. Pediatrician, Allergist, General Practitioner, etc.)
Name of Parents (If Minor): ____
Address: ___________________________________ City: _______________________ St: ____ Zip: ________
Home Phone: ____________________________ Business Phone: ___________________________________
How long has the patient lived in the present location? _______ Years
Previous Place of Residence: ____
Patient's Occupation: ____

Describe Briefly your/the patient's problem:

____

Effect of patient's illness on a Daily Living:

1) Number of school days missed in the last 12 months: ______
2) Number of workdays missed by patient in the last 12 months: ______
3) Number of doctor's visits for above symptoms in the last 12 months: _____

Family History

Has any direct family member had one of the following?
(including mother, father, sister, brother, son, daughter)

Asthma	Yes	No	Relationship ______________________________
Allergic Rhinitis	Yes	No	Relationship ______________________________
Sinusitis	Yes	No	Relationship ______________________________
Eczema	Yes	No	Relationship ______________________________
Hives	Yes	No	Relationship ______________________________
Food Allergy	Yes	No	Relationship ______________________________

Environmental History:

Type of Dwelling: ☐ House Apt Mobile Home
Age of Dwelling: ____ Years
Air Conditioning Type: Central Swamp Cooler Window Unit
Are there any damp or musty places in the house? Yes No
Where? ______________________________
Does anyone smoke at home? Yes No Who? ______________________________
What kinds of pets do you have? ______________________________ Not Applicable
Are they allowed in the house? Yes No
Are they allowed in the patient's room? Yes No
Are there other animals on the property? Yes No
List: ______________________________

Patient's Bedroom:
What is the composition of the pillows? ______________________________
Do any of the mattresses, Boxsprings or Pillows have allergy-proof covers?
☐ Yes ☐ No
Kind of floor covering in the room: ______________________________

Past Medical History:

Other Diseases for which you/the patient has been treated:
1. ______________________________
2. ______________________________
3. ______________________________

Operations:
Tonsillectomy & Adenoidectomy: ☐ Yes ☐ No At what age? ____ Years
Ear Tubes: ☐ Yes ☐No At what age? ____ Years
Sinus Surgery: ☐ Yes ☐No At what age? ____ Years
Other (Please Name)

____

Is there anything else which has not been mentioned, that you think is significant in contributing to the problem?

____

I give Dr. Daniel Suez permission to include this information as part of the medical record.

______________________________ ______________________________ ______________________________
Signature of Patient or Legal Guardian Relationship to Patient Date