Praana
center for asthma & allergy

Sam Koppula M.D.
6857 Kingery Hwy,
Willowbrook, IL 60527
Tel: 630-323-8800 ● Fax: 630-323-8829

Patient Registration Form

Name (full given name): _____ Date of Birth:_____ Sex: M F

Address: _____

City, State & Zip Code: _____

Home Phone # (_____)_____ Cell Phone # (_____)_____ **MAY WE LEAVE A MESSAGE?** ☐ **Yes** ☐ **No**

Patient's SSN: _____ Email Address:_____

Race: _____ Ethnicity: _____

Status: (please check one) ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Care Physician: _____ Referral Source: _____

Pharmacy: _____ City: _____ Phone: _____

Mail Order Pharmacy: _____ City: _____ Phone: _____

Emergency Contact
Name & Phone # _____Relationship:_____
*** REQUIRED***

If under 18: Mother's Name _____ Father's Name _____

Work/ Cell # _____ Work/ Cell #_____

Primary Insurance Information

Name of Policy Holder: _____ Policy Holder's DOB: _____

Social Security # _____ Relationship to patient: _____

Employer: _____Work # _____

Employer Address, City, State & Zip: _____

Home Address, City, State & Zip: _____Phone#_____
(If different from above)

Medical Insurance Company Name: _____ eff. Date _____

Does your policy require a co-pay? How much is your specialist co-pay? _____

Type of policy (circle) PPO MEDICARE SELF-PAY

Secondary Insurance Company Name: _____eff. Date _____

WE DO NOT ACCEPT HMO or MEDICAID

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to Praana Center for Asthma & Allergy and I am financially responsible for non-covered services and any and all co-pays. I also authorize the physician to release any information required in the processing of the claim.

X _____ X _____
Patient/Parent/Legal Guardian *Date*

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Consent for Treatment

I, _____, on behalf of myself and/or my child _____, hereby present for health care services to be rendered by Dr. Koppula, M.D. and hereby consent to the same. I understand that by my signature below, I do authorize and consent to the performance of all tests, procedures, treatments and/or teaching of medical devices which may be ordered by my physician or at the direction of my physician and I consent to such treatments and procedures as may be carried out by members of the medical staff and other health care providers at Praana Center for Asthma and Allergy. I have been informed that in receiving care and treatment from Dr. Koppula, M.D., I may receive care and treatment from my selected attending physician, his or her partners, colleagues and associates, nurses, ancillary staff and interns or residents who may be based in the office on a temporary basis for training purposes.

I understand that the practice of medicine is not an exact science. I further acknowledge that no guarantees have been made to me as to the results or outcomes that may be obtained through care and treatment from Dr. Koppula, M.D.

X _____ X _____
Patient/Parent/Legal Guardian *Date*

Acknowledgment and/or Receipt of Notice of Privacy Practices

I have received and been presented with the opportunity to review Dr. Koppula's Privacy Notice. The Notice or Privacy Practice provides detailed information about how the practice may use and disclose my confidential protected health information. I do hereby authorize the use and disclosure of my protected health information, including my medical records, test results and other information necessary for treatment, payment or health care operations.

X_____ X _____ X_____
Patient/Parent/Legal Guardian *Relationship to Patient* *Date*

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Assignment of Benefits and Payment Agreement

I hereby certify that I am the patient or duly authorized general agent of the patient authorized to furnish all information concerning responsibility for payment, insurance information and assignment of benefits. I understand that Dr. Koppula, M.D. requires that payment is due at the time of service, unless prior arrangements have been made. I also understand that copays and deductibles are due at the time of the visit. I understand that even though I may have insurance coverage for health care I am personally responsible for full payment of all services rendered by Dr. Koppula, M.D. I understand that some tests, procedures, treatments and teaching services may or may not be covered by my insurance company. I have been informed and understand that as a courtesy to me, Dr. Koppula, M.D. will file my claim with my insurance company pursuant to the assignment of benefits I authorize by my signature below.

If my insurance company does not pay Dr. Koppula, M.D. within a reasonable time period, I understand I will be responsible for payment in full. I further agree to be personally responsible for payment, in full, for any services not otherwise covered and paid for by insurance. I agree to pay for all services rendered and not otherwise covered by insurance, in full, within thirty (30) days of receiving a bill form Dr. Koppula, M.D. In the event that my account becomes delinquent for a period beyond sixty (60) days, I hereby acknowledge that I will be immediately responsible for the outstanding balance. I hereby authorize release of information necessary to file a claim with my insurance company and to assign any benefits payable be made on my behalf to Dr. Koppula, M.D., including but not limited to employment verification and credit reporting from a Consumer Reporting Agency as may be necessary. I request that payment of authorized Medicare benefits be made on my behalf to Dr. Koppula, M.D. for services furnished to me. I authorize the holder of medical information about me to release to CMS or other appropriate governmental agency and their agents, any information needed to determine benefits or benefits payable for related services.

I have read the financial policy for Assignment of Benefits and Payment Agreement and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

X_____ X _____ X _____

Signature of Patient/Guardian *Printed Name of Patient* *Date*

Missed Appointment/Cancellation Policy

As of January 1, 2013, all patients who fail to arrive for their scheduled appointments or do not cancel within 24 hours will be charged a missed appointment/cancellation fee of $25. This fee applies to all patients, regardless of their insurance status or insurer. Reminder: phone calls are a courtesy, and the lack of receipt of a reminder call is not a valid excuse for missed appointments. Missed appointment/cancellation fees are NOT covered by insurance, and will be the patient's personal responsibility to pay.

I have read the above statement and understand that I will be charged a fee of $25 for any missed appointment/late cancellation. I am aware that my insurance will not cover this charge and that I am personally responsible for the fee.

X _____ X _____

Patient/Parent/Legal Guardian *Date*

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Authorization to Discuss Medical Information (18YRS & OLDER)

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below. Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-ray Results ___Medications
___Lab Tests/Results ___Care Plan ___Summary of Medical Record
___Other (specify): _____

Indicate Confidential Information:

___Mental Health ___HIV information ___ Alcohol/Drug Information

Patient Name: _____

Date of Birth: _____

Information to be given to:

Individual #1:

Name: _____

Relationship: _____

Phone: _____

Individual #2:

Name: _____

Relationship: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

☐ _____ (specify expiration date or event) ☐ NO EXPIRATION DATE

I understand that:

I may inspect or copy the protected health information to be used or disclosed. I may revoke this authorization in writing by contacting your office, attention Administrator. This authorization is giving Praana Center the right to discuss my medical information with the one or more people listed above. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA. I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)

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DESIGNATION OF ANOTHER PERSON TO CONSENT FOR MEDICAL CARE (for minors only)

I, (parent/legal guardian) _____, cannot accompany my child,

(child's name)_____, to **Praana Center for Asthma & Allergy.**

Therefore, I give permission to (person's name; must be 18 years of age or older):

Individual 1: Name: _____

Relation to child _____ Phone# _____

Individual 2: Name: _____

Relation to child _____ Phone# _____

as follows (check ones that apply):

☐ I give permission for this person to accompany my child during their immunotherapy injection. I give consent for all medical treatment that may be required during this visit.

☐ I give permission for this person to accompany my child during their appointment with Dr. Koppula. I give consent for any procedures and/or medical treatment required during this visit.

Expiration of Permission: This form is VALID ONLY during the following time frame (check one):

☐ Minor turns 18 years of age

☐ Effective date: _____ / Expiration date: _____

X _____ X _____ Phone# _____

Signature of parent or legal guardian *Date*

IT IS YOUR RESPONSIBILITY TO INFORM OUR OFFICE IF A NEW INDIVIDUAL WILL BE ACCOMPANYING YOUR CHILD. IF THAT INDIVIDUAL IS NOT LISTED, WE CANNOT GIVE AN INJECTION NOR SEE YOUR CHILD FOR A VISIT

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Allergy Questionnaire

INSTRUCTIONS: Please answer the questions on this form as they relate to the person being evaluated.

I. Briefly describe the reason for your visit.

_____
_____
_____

II. Symptoms: Do you have any of the following?

Nasal:	**Yes**		**Yes**		**Yes**		**Yes**
Runny or Stuffy nose		Bad Breath		**Ear:**		**Skin:**	
Sneezing		Hoarseness		Full		Rash	
Itchy Nose		Throat Clearing		Painful		Hives	
Nose Bleeds		Itchy Throat		Ringing		Eczema	
Loss/Or Decrease of sense of Smell				Hearing Loss		Swelling	
Sniffing		**Eye:**		Itching		Itching	
		Red		**Chest:**			
Sinus:		Itching		Wheezing		**Other:**	
Headaches		Watery		Coughing			
Sore Throats		Dark Circles		Tightness			
Post Nasal Drainage		Puffiness		Shortness of Breath			
				Bronchitis			

If you have ASTHMA: Answer the following by circling the answer that applies:

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home?

1.All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

2. During the past 4 weeks, how often have you had shortness of breath?

1.All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

3. During the past 4 weeks, how often did you asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

1.All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

1.All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

5. How would you rate your asthma control during the past 4 weeks?

1.All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

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III. Medications: Please list all medications below.

Drug	Dose	Date Started	Drug	Dose	Date Started

IV. Triggers of Your Symptoms: Are your symptoms ___Year round, ___Seasonal, ___Both?

For each item below –check the box to indicate if your symptoms are worse when exposed to:

	Yes	No		Yes	No		Yes	No
Changes in Season			Animal Dander-Cat			Aspirin		
Changes in Weather			Animal Dander -Dog			With infections		
Changes in Humidity			Other(Animal)-			Emotional stress		
House dust			Cigarette Smoke			Food		
Blowing Dust			Perfumes			Other-		
Cut Grass			Newsprint					
Mold or Mildew			Chemical Odors					
Pollen			Alcohol					

V. Food Reactions: Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, and colic as an infant) after ingestion of any food or liquid? (If yes, specify below)._____

_____

_____

VI. Insect Sting Reactions: Have you ever had any systemic symptoms (hives, wheezing, shortness of breath, dizziness, fainting) after an insect sting? (If yes, specify below).

_____

_____

_____

VII. Medication Reactions:

Medication	Approximate Date	Symptoms

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VII. Medication Reactions (continued)

Have you ever had a reaction to x-ray dye? _____ Please specify? _____

Have you ever had a reaction to rubber products? _____ Please specify? _____

(i.e.: balloon, rubber ball, glove, or latex)

VIII. Previous Allergy Evaluations & Have Treatment:

Have you ever had allergy skin testing? ____Yes ____No

Were there any positive reactions? ____Yes ____No

If yes, Date: _____

What did you test positive to? _____

Have you ever received allergy injections? ____Yes ____No

If yes, dates: _____

Did your symptoms improve while you received injections? ____Yes____No

Did you ever experience an adverse reaction to an allergy injection? ____Yes____No

If yes, please specify: _____

IX. Environment

Do you live in a/an: House____ Apartment____

Is it located on/near: The water____ Vacant Land____ Industrial Area____ Canal____

Age of house: ____ years Single or Two-story____ Is there mildew present? _____

How long have you lived there: _____Years/Months

Type of air conditioning (Central, window, etc.) _____

Type of flooring: (carpet, wood, tile, vinyl, etc.) _____

How old is your mattress? _____

Is your mattress: foam _____ innerspring ____ encased in plastic ____cotton ____water bed ____ Other____

Do you have any pets? _____ List number and kind (i.e. dog, cat, bird, etc)

_____

Do your pets sleep in your bedroom? _____

Are there any smokers present in the home? _____

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X. Work History/Environment:

What is your occupation? _____

Is your work environment: Carpeted_____ Tiled_____

Is it air conditioned? _____Is smoking permitted_____

Are you exposed to chemicals or strong odors? _____

If yes, please specify: _____

Are your symptoms worse at work? ____Yes ____No If yes, please specify_____

Have you missed any time from work or because of your allergies? _____

How much time? _____

Comments: _____

XI. School History/Environment:

Have you missed any time from school because of your allergies? _____

How many days missed last year? _____

Do you feel school performance has been affected by allergies? _____

Comments: _____

XII. Immunizations: Approximate dates:

Pneumovax_____

Influenza (flu) _____

XIII. Past Medical History: Please list any surgeries/Hospitalizations/Medical Conditions.

_____

Childbirth: Dates_____

Dental History:

Have you worn braces? _____

Do you wear dentures? _____

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XIV. FAMILY HISTORY: Do immediate family members have any of the conditions listed below?

CONDITION	FAMILY HISTORY (CIRCLE)	WHO (i.e. mother, father, sibling , etc)
ALLERGIES	YES / NO	
ASTHMA	YES / NO	
COPD	YES / NO	
ECZEMA	YES / NO	
SINUS PROBLEM	YES / NO	
HIVES	YES / NO	
FOOD ALLERGY	YES / NO	
HIGH BLOOD PRESSURE	YES / NO	
DIABETES	YES / NO	
HEART ATTACK	YES / NO	
HEART DISEASE	YES / NO	
HIGH CHOLESTEROL	YES / NO	
STROKE	YES / NO	
CANCER (SPECIFY)	YES / NO	
THYROID DISEASE	YES / NO	
AUTOIMMUNE DISEASE	YES / NO	
OTHER	YES / NO	

XV. Systems Review: Have you ever had any of the following? (Check all items that apply).

___Frequent Headaches
___Hearing Loss
___Frequent Ear Infections
___Vision Disturbance
___Glasses
___Blindness
___Frequent Colds
___Coughing
___Wheezing
___Pneumonia
___Chest Pain
___Rapid Heart Beat
___Nausea/Vomiting
___Constipation
___Diarrhea
___Frequent Urination
___Painful Urination
___High Blood Pressure
___Fatigue
___Arthritis
___Bedwetting

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FEMALES ONLY:

Are your periods regular? ____Yes ____No

Interval____ Duration____

At what age did they begin? ____

MALES ONLY:

Prostate trouble? ____Yes____No

Impotence? ____Yes____No

What is your weight now? _____

Do you have any other chronic symptoms?

_____

_____

If your patient is a child, please complete the following:

Where born: _____

Age of mother at birth: _____

Was pregnancy/labor/delivery normal: _____If no, please specify_____

Birth weight: _____

Formula or breast fed: _____

Has child reached normal growth milestones? _____

If no, specify: _____

XVI. Social:

Where were you born? _____Raised? _____

How long have you lived in the house that you currently live in? _____

Do you exercise? _____How Often_____How Long_____

Do you drink alcohol? _____How Often_____ How much_____

XVII. Smoking:

Have you ever smoked? _____Yes _____No

If yes, how many years? _____ When did you stop_____

Average number of cigarettes per day? _____

Do you currently smoke _____ When did you start? _____

Do any other family members smoke._____