Jason N. Peet, MD
Amy Taylor, NP

PATIENT REGISTRATION INFORMATION

NAME:	DOB:
ADDRESS:	SOCIAL SECURITY:
CITY:	SEX:
STATE: ZIP:	MARITAL STATUS:
PHARMACY:	EMPLOYER:
PRIMARY PHONE:	EMERGENCY CONTACT:
SECONDARY PHONE:	EMERGENCY CONTACT PHONE:
WORK PHONE:	EMERGENCY CONTACT RELATION:

GUARANTOR INFORMATION

NAME:	DOB:
ADDRESS:	SOCIAL SECURITY:
CITY:	EMPLOYER:
STATE: ZIP:	EMPLOYER PHONE:
PRIMARY PHONE:	SECONDARY PHONE:

INSURANCE INFORMATION (THIS INCLUDES YOU MEDICARE)

PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER ID #:	SUBSCRIBER ID #:
GROUP #:	GROUP #:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER DOB:	SUBSCRIBER DOB:

I confirm that the above information is correct.

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Jason N. Peet, MD and all other providers employed by this clinic, when the clinic accepts assignment.
Authorization to Release Medical Information: I hereby authorize my Provider, Jason N. Peet, MD to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent of minor) Date

New Patient Information

Name: _____ Date of Birth: _____

Please List any Allergies to Medications: _____

Please List Any Medical Problems/Diagnoses:

_____

_____

Please List Any Surgeries, and the year performed:

_____

_____

Family History: Please list any Health Issues in your family:

_____

_____

Alcohol Use? Yes / No If yes, how many drinks per week? _____

Any Past or Present drug use? Yes / No If yes, what kind and how much? _____

Marital Status: _____ Children: How many? _____ Education Level: _____

Job Status: _____ Occupation: _____

Primary Care Physician: _____

Allergy / Asthma Questionnaire

Patient Name: **Date of Birth:**

List things you are allergic to: Your reaction to it:

What are the most bothersome symptoms that you want relief from:

How long have you noticed these symptoms? _____

Is there a seasonal pattern to these symptoms? _____ If so, what seasons?_____

Are your symptoms year round? _____

What do you think causes them? _____

Does traveling to certain areas make them better or worse?_____If so, where? _____

Do antihistamines or decongestants improve your symptoms? _____

Are symptoms affected by air conditioning? YES or NO - If YES, better or worse

Are symptoms worse with moist, humid air, like with frequent rain? YES or NO

Are symptoms worse with dry air, like during times of drought? YES or NO

Does anyone in your family have allergies or asthma? _____ celiac sprue? ____

Have you ever been allergy tested before? _____

Have you ever had a severe allergic reaction? _____

How long have you lived in the Hill Country? _____ in current house? _____

Check the following that apply to your home:

____ Recent renovation or remodeling ____ History of fire or water damage

____ Slab foundation ____ Manufactured (mobile home or RV) ____ window A/C unit(s)

____ Pier and beam foundation - if so, does water ever collect in crawl space? _____

____ Cat ____ Dog other pets or livestock_____

____ Problems with leaking pipe, humidity, or leaking roof / windows – currently / past (circle one)

____ Carpeting ____Fireplace _____ Basement _____ Indoor live plants _____ Greenhouse

Do you smoke? _____ Do any of your family members smoke? _____

Where do you work? _____ What is your position? _____

How long have you worked there? _____ Do you work indoors or outdoors? _____

Circle any of the following you work around:

chemicals, power tools, sawdust, hay, grain, gasoline, diesel, welding equipment, paint

Symptom checklist: (check all that apply)

____ Hive, Eczema (sensitive skin), or Skin Rash

____ Swelling of the face, lips, or tongue

____ Headache - describe location and severity of pain: _____

____ Sinus pain - describe location and severity of pain: _____

____ Fatigue

____ Muscle or joint pain

____ Fever: If so, how high? _____ When did you last have fever? _____

____ Weight loss or weight gain, if so, how much? _____

____ Night sweats

____ Frequent sinusitis, bronchitis, colds, or other respiratory infections

____ Nosebleeds

____ Sore throat

____ Itching or tearing eyes

____ Ringing of the ears

____ Blocking of the ears /difficulty popping ears

____ Vertigo: (circle) sensation of spinning or light headedness

____ Sneezing

____ Nasal Itching

____ Post-nasal drainage / runny nose: watery/clear or ropy/cloudy

____ Nasal obstruction / congestion: Right or Left nostril alternating or constant

____ Cough – do you bring up phlegm? YES or No

____ Wheezing, chest tightness, or shortness of breath

Which of the below make your symptoms worse:

____ specific season	____ change in temperature
____ upon awaking	____ windy days
____ dust	____ lying in bed
____ smoke	____ eating
____ working out in the yard	____ exercise
____ being outdoors	____ being indoors

____ Appetite increased or decreased ____ Crave certain foods If so, what?_____

____ Nausea ____ vomiting ____ diarrhea ____ cramping ____ constipation ____ bloating

____ IBS ____ "spastic colon" ____ Belching ____ Re-tasting of foods ____ Trouble swallowing

____ Stinging after defecation ____ Itching of anus ____ Itching of skin

____ Itching between shoulder blades ____ Itching of the roof of the mouth or throat

____ Itching of feet ____ Urinary burning, urgency, or frequency

Foods you eat: _____

Drinks you drink: _____

MEDICATION LIST

List all EYE DROPS you take: (you only need to list the names)

List all OVER THE COUNTER MEDICATIONS, VITAMINS, and SUPPLEMENTS you take: (you only need to list the names)

Do you take any protein supplements / shakes?

List all PRESCRIPTION MEDICATIONS you take: (you only need to list the names)

Are you pregnant? Have you had a Mastectomy?

This questionnaire was filled out by _____.

This questionnaire was reviewed with patient by _____.

Jason N. Peet, MD
110 East Live Oak
Fredericksburg, Texas 78624

Patient Name: **Date of Birth:**

Informed Consent for Allergy Testing

I have been made aware of the following:
Allergy testing will take several hours. The testing involves multiple injections of the skin and monitoring by the allergy nurse and physician.

Local reactions are common. We will monitor the size of the reactions and the length of time they last.

Generalized reactions occur less commonly and may include symptoms of itching of the skin; sudden itching of the nose, mouth, ears, and throat; hives, wheezing, coughing, tightness of the chest, plugging of the nose, or sneezing.

Although rare, serious reactions may result in significant respiratory distress or anaphylaxis, which may be life-threatening. A serious reaction usually occurs within 20 minutes. I do understand, though, that a serious reaction can rarely occur after I leave the medical facility.

I have had the opportunity to have all of my questions answered to my satisfaction.

I have been informed of the potential risks and benefits and available alternative therapies and I wish to proceed with allergy testing.

I am not pregnant.

Signature of patient or guardian:

_____ Date:_____

Dr. Jason N. Peet, M.D., P. A.

Jason N Peet, M.D.

Amy Taylor, NP

110 E. Live Oak

Fredericksburg, TX 78624

(830) 997-5559

BILLING NOTIFICATION TO PATIENTS

[Please Read This "Patient Waiver Form" Carefully and *SIGN* All Applicable Sections, *Prior to* Delivery of Health Care Services]

Payment at the Time of Service Policy

We file insurance as a courtesy to our patients. Until we can obtain a document from a patient's insurer to verify eligibility (EOB) under the applicable health plan (as it may or may not apply to any of this clinic's PPO contractual arrangements), we consider all professional services the responsibility of the patient. **At the time of service, all patients are responsible for co-pays, deductibles, and coinsurance**. If a patient's insurer determines that a specific health care service/visit/procedure is not covered under the applicable benefit plan, **all patients are also responsible for non-covered services at 100% of billed charges** (no PPO discount), and must pay for such at the time of service (or a billing statement will follow, Due Upon Receipt).

Financial Responsibility Agreement

I understand and agree that I am responsible for any and all charges as outlined above and will pay for such charges at the time healthcare services are rendered and/or upon receipt of a billing statement.

Signature Print Name Date

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Dr. Jason N. Peet, M.D.,PA. to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I had personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to Dr. Jason N. Peet, M.D.,P.A. all benefits, if any. If payment is made to me by my insurance company I will promptly turn payment over to Dr. Jason N. Peet, M.D.,P.A. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Jason N. Peet, M.D.,P.A. will be credited to my account, in accordance with this assignment.

Signature Print Name Date

Medicare Advantage Plans Authorization (or see ABN form)

I request that payment of authorized Medicare benefits be made to Dr. Jason N. Peet, M.D.,P.A. for any health care services provided to me. I authorize any and all health care professional(s) and/or facility(s) to release any of my medical information needed to determine these benefits or the benefits payable for related services to CMS and/or its agents. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "OTHER HEALTH INSURANCE" is indicated in the ITEM 9 box of the CMS-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer, payor or agency shown. If Medicare assignment applies, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. If Medicare Advantage PFFS or PPO plan applies, **the patient is responsible for patient co-pays, coinsurance, deductibles (PPO out-of-network) and/or non-covered services, per applicable Medicare Advantage benefit plan [co-pay, coinsurance and deductibles are based upon the charge determination of the Medicare Advantage Plan Payer]**.

Signature Print Name Date