Allergy & Asthma Specialists, P.S.C.

Lee S. Clore, Jr., MD - Board Certified Allergy/Immunology

Sara J. Martin, APRN

3604 Wathens Crossing | Owensboro, KY 42301 | (270) 684-6144

www.owensboroallergy.com

Welcome to our practice!

We look forward to meeting you at the time of your first appointment. Please telephone us at least 24 hours in advance if you must cancel, so we can schedule other patients who request to be seen. Please plan on arriving 30 minutes early, as there will be paperwork to fill out. Should you arrive more than 15 minutes late, your appointment may need to be rescheduled in an effort to see other patients in a timely manner. We realize your time is valuable and we want to give you prompt care if at all possible. If you do not call 24 hours in advance to cancel an appointment, your appointment will be considered a "no-show" and documented in your chart (extreme circumstances will be excused). If you have three or more "no-show" appointments, you will be terminated from the practice.

Due to the large amount of information asked during your initial visit, we ask that any patient under the age of 18 be accompanied by their parent or legal guardian (please bring paperwork indicating guardianship) [first visit]. If a parent is unable to accompany the patient, we ask that a copy of the parent's driver's license and insurance card are included with the Registration Form. We also ask that you ensure whoever is bringing the patient to the appointment is listed on the Registration Form.

Initial Visit

During your initial visit, Dr. Clore will conduct an evaluation before determining if skin testing or other procedures will be necessary. Additionally, we ask that you bring **all** of your current medications to your appointment. This information will help Dr. Clore prescribes a medication that will not interfere with other medications you may have been prescribed by another physician.

After your first visit, Dr. Clore may schedule a follow up visit with our nurse practitioner, Sara J. Martin, to make sure your personalized treatment plan is working for you. Sara has over ten years of experience working side by side with Dr. Clore.

Skin Testing & Procedure Information

If it has been determined that you will need skin testing, we will have you return after having held your antihistamines for an appropriate amount of time. Your physician will review what specific medications will need to be stopped in order to conduct skin testing. When you return for the skin-testing visit you should expect your visit to last at least 45 minutes.

Medical Records

If you or your child has seen another allergist-immunologist for treatment in the past, please bring copies of those records with you to your first appointment. In addition, please bring records of all immunizations.

Immunization Policy

Here at Allergy and Asthma Specialists, PSC, we care for patients with allergic immunologic diseases. Many of our patients have weakened immune systems, which predispose them to severe infection. Therefore, we try to prevent the patients from exposure to infection, if possible, when in our office for appointments. It has come to our attention that more and more families are choosing not to vaccinate their children. Children, who are not immunized based on the current US

guidelines, can place immune weakened or immune compromised patients at risk for severe and even life-threatening infection. Therefore, effective January 1, 2017, Allergy and Asthma Specialists will require that all patients be fully immunized according to the national guidelines. If, for any reason, the patients or families cannot comply with this policy, we respectfully ask that they find a healthcare provider more apt to meet their preferences. We sincerely appreciate all of our patients following this request, as we try to make sure our office is a safe environment for all patients that we see here in our clinic at Allergy and Asthma Specialists.

After-Hours Coverage

Our phone hours are 8:00- 11:30 a.m. and 1:00 - 5:00 p.m., Monday thru Thursday. During regular clinic hours, someone will be available to answer your questions as promptly as possible if you call our office number (270) 684-6144. If you need assistance after hours, please contact your primary care physician. Your primary care physician will determine whether or not additional physician support is needed. If you believe you have a medical emergency, please proceed to the nearest emergency room or acute care clinic.

Research Studies

We participate in selected research studies in the areas of allergy and asthma. Allergy & Asthma Specialists has been involved in conducting clinical research studies for more than 13 years. This is your opportunity to be a part of cutting-edge research treatment and be compensated appropriately for your time. Additionally, study medications are usually offered at no cost to you. Most studies in our office involve medications that are already available in the open market.
If you or anyone you know is interested in learning more about our research opportunities, please let one of our staff know. It is not necessary to be a patient of our office in order to participate.

Prescription Refills & Drug Samples

Please telephone your pharmacy if you need a prescription refilled. Please ask the pharmacist to fax our Owensboro office for approval at (270) 684-2944. **Allow us 24 hours** to process your refill. Additionally, patients on maintenance medications need to be seen in at least 6-12 month intervals.

We try to provide free drug samples (when available) when appropriate to our financially disadvantaged patients. However, **we must also have a 24 hour notice**, so please do not wait until your medication is gone before requesting a refill. In addition, providing samples on the same day of the request prevents us from providing timely care to that day's scheduled patients.

Payment for Services

Allergy & Asthma Specialists, PSC participates with most managed care plans, and will comply with the policies of each. We will be glad to file your primary, and secondary (if applicable), insurance for you. Since each patient's insurance plan varies widely, we ask that you do the following prior to your visit with us: contact your insurance company to verify if Dr. Clore is a participating provider and ask if a referral is needed from your primary care physician.

Co-pays and co-insurance payments are due at the time of service. Please note, some insurance plans require that a deductible be met prior to traditional insurance (i.e. co-pays & co-insurance) "kicking in." If your policy has a deductible that has not been met or co-insurance (percentage) that will need to be paid, you may pay in one lump sum, or arrange monthly payments per the schedule below:

Account Balance	Payment Time Period
Less than $50.00	Next visit
$50.01 - $600.00	6 Months
Greater than $600.01	12 Months

Note: New services rendered may increase the amount of the outstanding balance and may affect the minimum payment required.

Our office will not know about your total financial responsibility until we have filed your claim, and insurance has responded.

Please be sure to verify Dr. Clore's participation with your insurance provider prior to your appointment. If Dr. Clore does not participate with your insurance plan, or the services rendered are not covered by your plan, payment will be expected at the time the service is provided. However, as a courtesy, we will file a claim with your insurance company. Also, if your insurance company denies payment to Allergy & Asthma Specialists, PSC for services performed, you accept responsibility for the charges. We accept cash, checks, debit cards, MasterCard, Visa, and medical flexible spending cards.

If you are unable to pay for services when they are rendered, please telephone our insurance and billing coordinator before your visit to establish a payment plan.

In the event of default or if your bill must be referred to a collection agency or attorney for collection, you agree to pay court costs and reasonable attorney fees if suit is filed to recover your account.

You agree, in order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via email or text message using any email address you provide. Methods of contact may include the use of prerecorded and artificial voice messages and/or use of an automated dialing device.

Sick Visits

We do not offer a walk-in clinic. If you walk in, you will be asked to go to an urgent care center or the emergency room. Please contact our office if you are sick and need to be seen. If we have availability, we will try to get you in same business day, or next business day, to be seen by either Dr. Clore or Sara J. Martin, APRN.

Dr. Clore's Credentials

Dr. Lee S. "Stant" Clore, Jr. has a Bachelor's degree in Chemistry from the University of Kentucky, and a Doctor of Medicine degree also from U K. He completed an internship and residency in pediatrics at Children's Hospital of the King's Daughters in Norfolk, Virginia. He then completed a fellowship in allergy-immunology at the Medical College of Georgia in Augusta, Georgia. He is also a member of numerous professional organizations. He is board certified in pediatric and adult allergy-immunology by the American Board of Allergy and Immunology.

Sara J. Martin's Credentials

Mrs. Martin has worked with Allergy & Asthma Specialists for 10 years now. She began her career here as a registered nurse and then worked her way through school. She graduated in 2015 from Maryville University in St. Louis, Missouri with a master's of science in nursing, family nurse practitioner. We are excited to add Mrs. Martin to our team as a provider!

Aesthetic Specialists of Owensboro

We are pleased to now offer aesthetic services in our office. Hannah Horn is a certified medical esthetician. Hannah offers waxing, skin care, acne treatments, facials, chemical peel, micro needling and microdermabrasion. If you are interested in speaking with Hannah, please let our front office team know or contact Hannah at 270-302- 4435.

Sincerely,

Dr. Clore and Staff

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact our privacy officer, Jean Owen at Allergy & Asthma Specialists, P.S.C., 3604 Wathens Crossing, Owensboro, KY 42301.

Who Will Follow This Notice:
This notice describes our office's practices. We may share information with each other for your care.

Our Pledge Regarding Medical Information:
We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care you receive at this office to provide you with quality care and to comply with legal requirements. This notice will tell you about the ways in which we use and disclose your medical information. We also describe your rights and the obligations we have regarding the use and disclosure of medical information. We are required by law to make sure that medical information that identifies you is kept private; give you this notice of our privacy practices with respect to your medical information; and follow the terms of the current notice.

How We May Use and Disclose Medical Information About You:

For Treatment – We may use information about you to provide you with medical treatment. We may disclose medial information about you to office staff and others involved in your care.

For Payment – We may use and disclose information about you for insurance and payment services.

For Health Care Operations – We may use and disclose information about you for practice operations to make sure that you receive quality care and for learning purposes.

Appointment Reminders – We may use and disclose information to contact you about appointments.

Phone Messages – We may call and leave messages with whoever answers the phone at your house or on your answering machine unless directed otherwise. **Feel free to change as necessary**.

Treatment Alternatives – We may use and disclose information to tell you about treatment options.

Health-Related Benefits and Services - We may tell you about health-related benefits or services.

Individuals Involved in Your Care or Payment for Your Care – We may release medical information about you to a friend or family member who is involved in or helps pay for your medical care. We may disclose medical information about you to assist in a disaster relief effort.

As Required By Law – We will disclose information about you when required to do so by law.

To Avert a Serious Threat to Health or Safety – We may use and disclose information about you to prevent a serious threat to your health and safety, the public or to another person.

Special Situations:

Organ and Tissue Donation – If you are an organ donor, we may release information to organ banks.

Military and Veterans – We may release information about military personnel as required.

Public Health Risks – We may disclose information about your for public health activities.

Health Oversight Activities – We may disclose information about your for public health activities

Lawsuits and Disputes - We may disclose information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement – We may release information to a law enforcement official as required by law.

Coroners, Medical Examiners and Funeral Directors - We may release information to a coroner, medical examiner or funeral director as necessary.

National Security and Intelligence Activities and Protective Services for the President – We may release information about you to authorized federal officials for national security activities.

Inmates - We may release information about inmates to a correctional institution or law enforcement.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy - You have the right to inspect and copy your medical information. This includes medical and billing records, but does not include psychotherapy notes. You must submit your request in writing to Jean Owen, Allergy & Asthma Specialists, PSC, 3604 Wathens Crossing, Owensboro KY 42301. We may charge a fee for the costs of copying. We may deny your request to inspect and copy. You may request that the denial be reviewed. Another neutral health care professional, not the person who denied your request, will review your request and the denial. We will comply with the outcome of the review.

Right to Amend - If you feel that your information is incorrect or incomplete, you may ask us to amend the information. You may request an amendment as long as the office has this information. Your request must include the reason, be made in writing and submitted to Jean Owen, Allergy & Asthma Specialists, PSC, 3604 Wathens Crossing, Owensboro KY 42301. We may deny your request if you ask us to amend information not created by us, unless the person that created the information is no longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures - You have the right to request a list of the accounting of disclosures we made of your medical information. You must submit your request in writing to Jean Owen, Allergy & Asthma Specialists, PSC, 3604 Wathens Crossing, Owensboro KY 42301. Your request must state a time period, not longer than six years. Your first requested list within a year is free.

Right to Request Restrictions - You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment, and health care operations or to someone who is involved in your care or the payment for your care. **We are not required to agree to your request.** If we agree, we will comply with your request unless the information is needed in an emergency. You must make your request in writing to Jean Owen, Allergy & Asthma Specialists, PSC, 3604
Wathens Crossing, Owensboro KY 42301. You must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications - You have the right to request that we communicate with you about medical matters in a certain way or location. You must make your request in writing to Jean Owen, Allergy & Asthma Specialists, PSC,
3604 Wathens Crossing, Owensboro KY 42301. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We have the right to deny your request.

Right to a Paper Copy of This Notice - You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes to this Notice:
We reserve the right to change this notice and make the revised notice effective for information we already have about you as well as any future information. We will post a copy of the current notice in the office. Each time you register at the office we will offer you a copy of the current notice.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact Jean Owen, 3604 Wathens Crossing, Owensboro, KY 42301. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

Other Uses of Medical Information:
Other uses and disclosures of information not covered by this notice will be made only with your written permission. You may revoke that permission in writing at any time. Understand that we are unable to take back any permitted disclosures, and that we are required to retain records of your care.

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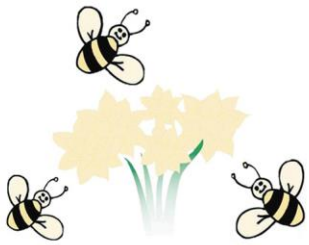

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I, _____ (Parent/Legal Guardian) of _____ (City & State) do hereby state that I am the parent or legal guardian of _____ (Patient/Child's Name) a minor born ___/___/_____ (mm/dd/yyyy) who resides with me at _____ (Street Address). I hereby give my permission and written consent to _____ (Person Accompanying Child) to receive medical information and to make medical decisions on behalf of the above-named child or render any and all medical and/or surgical treatment to the above-named child deemed necessary in connection with an injury or illness in my absence from the medical office of Allergy & Asthma Specialists, P.S.C. This consent is effective from ___/___/_____ (mm/dd/yyyy) until I terminate this consent in writing and give to Allergy & Asthma Specialists, P.S.C.

Signature: _____ Date: _____
(Parent named above)

Witness (must not be parent, guardians, or children listed above):

Signature: _____ Date: _____

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Acknowledgement of Policy and Procedures and Informed Consent

I, _____ (name of patient or legal guardian), on _____ (date) acknowledge that

Please initial the following:

_____ I have read and understand all the enclosed information contained within the New Patient Packet.

_____ I authorize my signature on all insurance and Medicare claim forms at the office of Allergy & Asthma Specialists, P.S.C. for payment directly to the physician, nurse practitioner, or physician assistant for services rendered to me/patient. I authorize this office to make and send copies of medical records to entities involved with filing my insurance claims or to other physicians involved in my care. **I understand that I/patient am responsible for charges incurred regardless of whether my insurance pays or not.** I/patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services I/patient received. I agree that this statement applies to all current and future claims or visits.

_____ I acknowledge that I have received the HIPAA Notice of Privacy Practices. Should I have any questions, I can direct them to the Practice Administrator.

Patient Name (Please Print): _____

Signature of Patient or Legal Guardian: _____

Date:_____

A copy of this page will be returned for your record.

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General Informed Consent for Allergy Skin Testing

Allergy skin testing is valuable to help determine the presence of specific allergy sensitivity. Skin testing utilizes allergen extracts such as pollen, dust, animal dander, bee venom (honey bee, wasp, yellow jacket, or hornets), foods or other medications such as Lidocaine.

Specific IgE testing (an alternative blood allergy test) is available and may be performed; however skin testing is rapid and provides more clinically relevant results. A very small percentage of patients may react adversely to testing and experience hives, itching separate from the skin test site, runny nose, or may wheeze.

The two types of testing performed include:

___ Prick test: a small amount of allergen is placed on a small plastic testing device and placed on the forearm or back to prick the skin.

___ Intradermal test: A small amount of allergen extract is injected under the skin in the forearm or upper arm with a very small allergy needle. Intradermal testing to foods are NEVER performed.

Upon completion of testing, you will be evaluated by your allergist to review your results. Your allergist may suggest changes to your medical therapy, review environmental controls, or request avoidance of allergens to which you are allergic. Immunotherapy (allergy shots) may be discussed as an option based upon the correlation of the skin tests and response to current medical therapy.

Consent and Acknowledgement:
My signature below is documentation that I have read this form, understand the risks and benefits and agree to its contents. I voluntarily give my authorization and consent to Dr. Clore and their qualified allergy staff (MA/LPN/RN) to perform these tests and procedures and render any additional care that may be become necessary in the course of skin testing.

_____/Date_____
Signature of patient (parent if under 16)

_____
(Please Print Name)

Allergy & Asthma Specialists, P.S.C
Registration Form

Patient Information:

Patient Name: _____
First M Last

Birth Date:_____ Sex: Male____ Female____

With whom does the patient reside: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Marital Status (circle one):

Single Married Divorced Widowed

Race: ☐ Hispanic/ Latino ☐African American ☐Asian ☐American Indian ☐White/Caucasian

Pharmacy: _____

Primary Care Physician First and Last Name:

_____

Emergency Contact: _____

Relationship: _____

Phone number(s): _____

Responsible Party Information:

Name: _____

Address: _____

City, State, Zip: _____

Phone number(s): _____

Insurance Information (ALL INFORMATION BELOW IS REQUIRED):

Primary Insurance:

Insured Name: _____
First M Last

Insured Birth Date: _____

S.S. Number: _____

Relation to Patient: _____

Employer: _____

Secondary Insurance:

Insured Name: _____
First M Last

Insured Birth Date: _____

S.S. Number: _____

Relation to Patient: _____

Employer: _____

I AUTHORIZE YOU TO GIVE THE FOLLOWING PERSON(S) MEDICAL INFORMATION ON MY BEHALF

Name:	**Relationship:**	**Discuss Financial Information:**
_____	_____	Yes No
_____	_____	Yes No
_____	_____	Yes No

I give you permission to leave messages on my home answering machine or voicemail: Yes No

I give you permission to contact me via email, my email address is: _____

Please indicate how you prefer to receive appointment reminders (check one):

____ Please call me at this phone number:_____

____ Please email me at this address: _____

If you cannot keep your appointment for any reason, please contact us at least 24 hours prior to your scheduled appointment time. If you do not keep your appointment, or cancel without a 24-hour notice, you will be charged a $30 no-show fee. Three no-shows result in termination as a patient.

Signature: _____ Date: _____

Print Name

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IMMUNIZATION POLICY STATEMENT

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Thank you,
Lee S. Clore, Jr., M.D.

Patient Name (Please Print): _____

Signature of Patient/Legal Guardian: _____

Date: _____

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Initial Allergy Evaluation

Date: _____ Patient Name: _____

Primary MD: _____ Age: _____ Gender: Male ☐ Female ☐

Referred by: _____ Date of Birth: _____

Occupation: _____ Address: _____

Business Phone: _____ _____

Home Phone: _____

Please describe the primary medical problem which prompted you to seek evaluation today.

SYMPTOMS: Are you bothered by the following symptoms?

Itchy/watery eyes	Facial pain/tenderness	Chest tightness
Dark circle under eyes	Nighttime cough	Itchy skin
Runny Nose	Loss sense taste/smell	Dry skin
Stuffy nose/nasal congestion	Chronic bad breath	Hives
Nasal itch/rub	History of nasal polyps	Swelling
Bouts of sneezing	Nosebleeds	Frequent ear infections
Ringing/popping ears	Cough	Frequent Pneumonia
Headaches	Wheeze	
Frequent sinus infections	Shortness of breath	

AGGRAVATING FACTORS: Circle all the things that cause your symptoms.

Dust	Mold/mildew	Time of day – am/pm
Pollen	Colds/infections	Home
Cut grass/rake leaves	Indoors	Workplace
Cats	Outdoors	Temperature changes
Dogs	Weather changes	Food_____
Other animals_____	Smoke	
Feathers	Strong odors	

Have you had symptoms >2 weeks a year? Yes No

How long have you had symptoms? _____

Do symptoms occur year round? Yes No

Are symptoms worse in certain seasons? Yes No

Circle the worst season(s): Spring Summer Fall Winter

If you have been on antibiotics for sinus infections:

How many times have you been treated in the past 12 months? _____

What antibiotics have you used? _____

Have you ever received a CT scan, chest x-ray or sinus x-ray? Yes No

If yes, please list results: _____

Have you ever had sinus surgery? Yes No If yes, how many? _____

Have you been on steroids or received a steroid shot for your asthma? Yes No

Patient Name: _____
Date of Birth: _____

If you have had cough, shortness of breath, wheezing, or chest tightness:
Have you been on steroids or received a steroid shot for your breathing? Yes No
Have you ever been prescribed an inhaler? Yes No
Do you use a spacer with your inhaler? Yes No
Do you wake up at night because of chest symptoms? Yes No
Circle any circumstance appropriate to your asthma:
ER visits Hospitalization Intubation ICU admission Pneumonia

If you have had hives/swelling:
How often have you had hives or swelling? _____ When did it first begin? _____
How long does each individual hive last? _____
Do they itch? Yes No Are they painful? Yes No
Have you ever had hives/swelling in the past? Yes No
Do you experience shortness of breath, wheeze, chest tightness, abdominal pain, throat fullness, dizziness, or diarrhea? Yes No (circle where appropriate)
Have you recently experienced fevers, chills, night sweats, swollen glands, swollen joints, weight gain or loss?
Yes No (circle where appropriate)
What "triggers" the hives/swelling (circle)

Stress Vibration Exercise Medications
Sunlight Food Pressure Water
Work Heat Cold Do not know

Current Medicines and Dosages (Prescription and Over-the-Counter):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Medical History/Review of systems
Have you ever been diagnosed with any of the conditions below? Yes No

	Yes	No		Yes	No
ADHD	☐	☐	Migraines/frequent headaches	☐	☐
Asthma	☐	☐	Nasal injury	☐	☐
Cancer	☐	☐	Osteoporosis or Osteopenia	☐	☐
Depression/anxiety	☐	☐	Recurrent Pneumonias	☐	☐
Developmental delay	☐	☐	Positive TB skin tests/Tuberculosis	☐	☐
Diabetes	☐	☐	Prematurity	☐	☐
Elevated cholesterol	☐	☐	Prostate disease	☐	☐
GERD/Ulcers/GI problems	☐	☐	Seizures/Neurologic disorder	☐	☐
Glaucoma/cataracts	☐	☐	Severe infections	☐	☐
Heart disease	☐	☐	Stroke	☐	☐
Hypertension	☐	☐	Thyroid disease	☐	☐
Irritable bowel syndrome	☐	☐	Other _____		
Kidney stones	☐	☐			

Patient Name: _____
Date of Birth: _____

Surgical History

Please circle any surgeries you have previously had:

Adenoid removal	Gall bladder removal	Nasal/sinus surgery
Appendectomy	Hysterectomy	Open heart surgery
Ear tubes	Knee replacement	Tonsillectomy

Other: _____

Birth History

Were you born prematurely? Yes No If yes, how many weeks early? _____
Did you have any problems with breathing at birth? Yes No
Any complications/hospital stays in the first year? Yes No
Any developmental delays or special evaluations required? Yes No
Breast or bottle fed? _____ Which formula? _____

Immunization History

Are your routine childhood vaccinations up to date? Yes No if no, why? _____
Do you get a flu shot? Yes No
Have you ever had a reaction to shots? Yes No Please describe _____

Allergy History

Any medication allergies? Yes No Please list and describe reaction: _____
_____
_____
Any problems related to diet? Yes No Please describe: _____
_____
_____
Are these foods tolerated? Yes No
Cow's Milk Eggs Fish Shellfish Peanut Other nuts Soybean Wheat
Any insect sting reactions? Yes No _____
Any latex reactions? Yes No _____
Prior allergy testing? Yes No
Were you on injections? Yes No if yes, did they help? Yes No

Family History

Do any of your <u>family members</u> have a history of:

	Who: (father, mother, grandmother, etc.)
Asthma	_____
Cystic Fibrosis	_____
Eczema	_____
Food allergies	_____
Hay fever	_____
Hives/swelling	_____
Insect sting reactions	_____
Migraines/headaches	_____
Recurrent infections	_____
Stomach problems	_____
Other	_____

Patient Name: _____
Date of Birth: _____

SOCIAL HISTORY

(please circle)

1. Marital status: Married Divorced Single Widowed
2. Alcohol use: Never/rarely Socially More than 3x/week
3. Exercise: Never/rarely Occasionally More than 3x/week
4. Drug Use: Never In the Past Currently
5. Tobacco Use: Never In the Past Currently

If you answered yes to Tobacco use, please answer the following:

How much? _____

For how many years? _____

When did you stop? _____

Work/School

1. What is your occupation? _____
2. If a student, what grade are you in? _____
3. What are your hobbies? _____
4. Are your symptoms worse at work? Yes No
5. Any specific exposures at work? Yes No _____
6. Do you get better on vacation? Yes No
7. How many days did you miss school or work in the past year? _____
8. If child, is he/she in daycare? Yes No
9. How many other persons are in the household? _____

ENVIRONMENTAL HISTORY

General (circle where appropriate)

1. Where do you live? House Apartment Trailer Condo Other: _____
2. How long have you lived there? _____ How old is it? _____
3. Pets (If yes please specify) Yes No

Cat	Indoor	Outdoor	Both
Dog	Indoor	Outdoor	Both
Other:_____	Indoor	Outdoor	Both

4. Smokers in the home? Yes No
5. Is your home air conditioned? Yes No If yes, central or window?
6. Do you keep your windows closed? Yes No
7. Do you have a humidifier? Yes No
8. Do you have an electrostatic air filter? Yes No
9. Do you have moisture problems in your home? Yes No
10. Do you have a basement? Yes No Is it damp? Yes No
11. Do you have: Carpet Wood Vinyl flooring
12. Have you noticed insects or cockroaches in the home? Yes No

Bedroom

1. Type of bed? Regular Foam/Latex Waterbed Crib mattress
2. Plastic encasement mattress? Yes No How many? _____
3. Type of pillow: Feather Synthetic Cotton
4. In the bedroom, do you have: Carpet Wood Vinyl flooring

Allergy & Asthma Specialists, P.S.C.

Lee S. Clore, Jr., MD - Board Certified Allergy/Immunology

Sara J. Martin, APRN

3604 Wathens Crossing | Owensboro, KY 42301 | (270) 684-6144

www.owensboroallergy.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Date of Birth:_____

Phone Number: _____ Social Security #:_____

Address:_____ City/State/Zip:_____

INFORMATION TO BE RELEASED FROM:

Facility Name:_____
Address: _____
City/State/Zip: _____
Ph. No.: _____

INFORMATION TO BE RELEASED TO:

Facility Name: Allergy & Asthma Specialists, PSC
Address: 3604 Wathens Xing
City/State/Zip: Owensboro, KY 42301
Ph. No.: 270-684-6144

Information to be released:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, skin tests/results, breathing tests)
- ☐ All medical records
- ☐ Other: _____

Purpose for which disclosure is being made:

- ☐ Personal Use
- ☐ Legal investigation
- ☐ Other: _____
- ☐ Sharing with other health care providers
- ☐ Transferring my care to a new health care provider

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Jean Owen, Practice Administrator, Allergy & Asthma Specialists, PSC, 3604 Wathens Crossing, Owensboro, KY 42301. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that the Practice may not condition treatment or payment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

Patient Name:_____ Date:_____

Patient or Parent/Guardian Signature: _____