LANGFORD ALLERGY, LLC

Jeffrey W. Langford, M.D., A.E.-C.
Sonia Mathew, M.D

6501 Peake Road
Building 1000
Macon, GA 31210

201 Tift College Drive
Forsyth, GA 31029

850 West Thomas Street
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128 Tommy Stalnaker Drive
Suite 200
Warner Robins, GA 31088

P: 478.787.4728
F: 478.607.2513

LangfordAllergy.com

Pediatric and Adult Allergy, Asthma, and Immunology
Multiple Locations in Middle Georgia

New Patient Information/ Patient Update

Patient Number: _____ Social Security Number: _____

Patient's Name: _____ Today's Date: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Street Address: *(Check Perm. Or Temp.)* ☐ Perm ☐ Temp _____

Apt./Suite/Unit: _____ City/State: _____ Zip Code: _____

Email: _____ Primary Language Spoken: _____

Marital Status: *(Choose One)*

☐ S ☐ Div.
☐ M ☐ Sep.
☐ W ☐ DP

Race: *(Check all that apply)*

☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Other

Ethnicity: *(Choose One)*

☐ Hispanic
☐ Non-Hispanic

Preferred Method of Communication: ☐ Phone Call ☐ Text ☐ Email ☐ Don't Call

Home Phone: _____ Mobile Phone: _____

Mobile Phone: _____ Business Phone: _____

Preferred Phone: _____ Occupation of Patient: _____

Patient's Employer: _____ How Long Employed: _____

Employer's Street Address: _____

City/ State: _____ Zip Code: _____

Primary Care Physician Name: _____

Phone: _____ Fax: _____ Were You Referred by a Physician? ☐ Y ☐ N

Spouse/Domestic Partner Name: _____ Phone: _____

Employer: _____ Occupation: _____

Work Phone: _____ Employer's Street Address: _____

City/State: _____ Zip Code: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone: _____ Address: _____

City/State: _____ Zip Code: _____

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name: _____

Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____ Mobile Phone: _____

Mother's Employer: _____ Occupation: _____

City/State: _____ Zip Code: _____

Employer's Street Address: _____ Business Phone: _____

Social Security Number: _____ Date of Birth: _____

Father's Name: _____

Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____ Mobile Phone: _____

Father's Employer: _____ Occupation: _____

City/State: _____ Zip Code: _____

Employer's Street Address: _____ Business Phone: _____

Social Security Number: _____ Date of Birth: _____

INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____ Group Number: _____

Primary Insurance Holder: _____

Employer: _____ Date of Birth: _____

Social Security Number of Subscriber: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Primary Insurance Holder: _____

PHYSICIAN RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Langford Allergy, LLC of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim as required by law. I request payment of medical insurance benefits either to myself or to Langford Allergy, LLC who accepts assignment. I understand that I am financially responsible for charges regardless of coverage.

Patient's/Guarantor's Signature: _____

Date: _____

Notice of Mid-Level Providers

I understand that Langford Allergy, LLC employs a team approach to care for its patients. This team may include physicians, nurse practitioners, or physician assistants. I understand that the mid-level providers provide care under the supervision of the physician and that they may be a part of my healthcare team. This team approach allows my care to be followed by the doctor and the mid-level providers.

Patient Consent to the Use and Procedure of Health Information for Treatment of Patient or Healthcare Operations

_____, understands that as a part of my health care, Langford Allergy, LLC originates, maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify these services billed were provided
- A tool for routine healthcare operations such as assessing quality and review in the competence of healthcare professionals

I understand that Langford Allergy, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.520 of the Code of Federal Regulations.

I further understand that Langford Allergy, LLC reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Langford Allergy, LLC change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____ _____

Signature: Date:

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Patient History Form

Today's Date: _____

Last Name: _____ First Name: _____

Age: _____ DOB: _____ Gender: ☐ Male ☐ Female

Primary Care Physician: _____

Referred by: ☐ Primary Care Physician: ☐ Other Physician - Name: _____

Main Complaint: _____

Past Medical History: *(Please list all current and previous medical problems)* _____

_____

List all surgeries and hospitalizations with associated dates: _____

_____

List all current medications: _____

_____

Previous Allergy Testing/Therapy: ☐ Skin Test ☐ Blood Test ☐ I have never had allergy testing

Allergy test results and date of test: _____

Allergy Shots in past?: ☐ No ☐ Yes When Started: _____ When Stopped: _____

Reason for stopping: _____

Box Information For Pediatric Patients Only:

Birth weight: _____lbs. _____oz. Type of Delivery:_____

Complications during pregnancy, delivery and/or neonatal course: ☐ None ☐ Yes, Explain: _____

_____

Immunizations/Vaccinations up-to-date? ☐ Yes ☐ No - Explain: _____

For WOMEN of child-bearing age: Are you pregnant? ☐ No ☐ Yes

MEDICATIONS: Please be ready to list all medications (INCLUDING ALL INHALED MEDICATIONS), vitamins and herbal supplements including doses and frequencies. The nurse will obtain this information from you during your office visit.

ALLERGIES: Please be ready to list all ADVERSE EFFECTS and ALLERGIES to a medication, drug, food, insect, or anything else. Be sure to give the approximate date of the reaction with a description of the reaction. The nurse will obtain this information from you during your office visit.

FAMILY HISTORY:
Please state any medical problems in the family: ☐ No significant medical problems in the family

Mother: _____ Father: _____

Brothers: _____ Sisters: _____

Other: _____

SOCIAL HISTORY:

Box Information For Pediatric Patients Only:

Does your child attend day care?: ☐ No ☐ Yes ☐ Not applicable School Grade: _____

Smoking exposure: ☐ No smoke exposure ☐ Parent, relative or guardian smoke outdoors only

☐ Parent, relative or guardian smoke indoors, outside and/or in the car.

Occupation: _____

Tobacco Use: ☐ No ☐ Yes - Type: _____

Do you currently smoke? ☐ No ☐ Yes - Number of years: _____ Number of packs per day _____

If not currently smoking, have you ever smoked in the past: ☐ No ☐ Yes - Number of years smoked: _____

When did you quit? _____

Alcohol use: ☐ None ☐ Yes - Frequency:_____ ☐ Occasional ☐ Other: _____

Drug use: ☐ None ☐ Yes - Explain: _____

ENVIRONMENTAL HISTORY:
Do you live in a: ☐ House ☐ Apartment ☐ Other: _____ ☐ Age of Home/Apartment: _____

Length of time living in your home: _____

Check if you have the following:

☐ Basement ☐ Crawl space ☐ History of flooding or water damage in home

☐ Obvious mold in home, basement or crawl space ☐ Problems with roaches, mice or rats in home

☐ Carpet ☐ Area rugs ☐ Use of dust mite encasements

Heating/Air conditioning/Air Quality:

☐ Central forced air conditioning and heating ☐ Window unit air conditioning ☐ No air conditioning

☐ Gas heating ☐ Electric heating ☐ Other heating –Type: _____

☐ Gas stove ☐ Electric stove ☐ Humidifier ☐ Dehumidifier

☐ Humidity gauge ☐ Vacuum at least weekly ☐ Central air filter ☐ Portable air filter present

☐ HEPA air filter present ☐ Fireplace present

Pets:
☐ Cat – How many? ____ ☐ Dog – How many? ____ ☐ Other: _____

REVIEW OF SYMPTOMS:
(Please check any symptoms that you have had in the past 3 months)

Constitutional Symptoms:
☐ Fever ☐ Chills ☐ Fatigue ☐ Headaches
☐ Night Sweats ☐ Decreased appetite ☐ Difficulty sleeping ☐ Weakness
☐ Weight Loss ☐ Weight Gain

Eyes:
☐ Wear contact lenses ☐ Blurred Vision ☐ Double Vision ☐ Swelling
☐ Excess tearing ☐ Itching ☐ Redness

Ears/Nose/Mouth/Throat:
☐ Hearing loss or ringing ☐ Earaches or drainage ☐ Itching or popping of ear ☐ Sneezing
☐ Snoring ☐ Nasal congestion ☐ Nose Bleeds ☐ Sinus pressure
☐ Nasal itching ☐ Post-nasal drip ☐ Runny nose ☐ Sore throat

Cardiovascular (Heart):
☐ Chest pain ☐ Irregular heart beat ☐ Heart murmur ☐ Heart racing
☐ Swelling of legs ☐ Shortness of breath lying down

Respiratory (Lungs):
☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Chest tightness
☐ Coughing up blood ☐ Difficulty getting air OUT

Gastrointestinal:
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Heartburn ☐ Abdominal pain ☐ Bright red blood in stools ☐ Black stools

Urinary:
☐ Frequent urination ☐ Painful/burning urination ☐ Blood in urine ☐ Difficulty stopping urination
☐ Difficulty starting urination ☐ Large urinary volume

Musculoskeletal:
☐ Painful joints ☐ Swelling of joints ☐ Redness of joints ☐ Muscle pain
☐ Back pain ☐ Pain down back of legs

Integumentary (Skin):
☐ Dry Skin ☐ Itchy skin ☐ Rash ☐ Change in skin color
☐ Nail changes ☐ Change in hair

Neurological:
☐ Recurrent headache ☐ Seizures ☐ Numbness or tingling ☐ Muscle weakness
☐ Tremors ☐ Loss of sensation ☐ Loss of balance ☐ Memory difficulty

Psychiatric:

☐ Nervousness ☐ Depression ☐ Confusion ☐ Insomnia

Endocrine:

☐ Heat/Cold Intolerance ☐ Excessive thirst ☐ Thyroid swelling/Goiter ☐ Glandular or hormone problem

Hematologic/Lymphatic (Blood and Lymph nodes):

☐ Easy bleeding ☐ Easy bruising ☐ Difficult to stop bleeding ☐ Enlarged glands/lymph nodes

Allergic/Immunologic:

☐ Hay fever symptoms ☐ Bee/Wasp/Fire ant allergy ☐ Frequent pneumonia ☐ Frequent skin infections

☐ Drug Allergies: _____ ☐ Food Allergies: _____

Other:

☐ Other: _____

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PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Langford Allergy, LLC as your healthcare provider. We are committed to provide you with the best quality care. We ask that you please read and sign this form acknowledging your understanding of our patient financial policies.

Insurance Coverage: It is the patient's responsibility to be familiar with their insurance coverage, policy provisions, exclusions and limitations, as well as requirements for authorizations. We attempt to verify that your coverage is active at the time of your visit. However, we depend on you to provide us with the most accurate information. If for any reason, your coverage is not active you must know that the cost of the visit is your responsibility.

- **Change of Insurance:** If you have had any changes to your insurance coverage, you must notify us immediately.
- **Referrals:** It is your responsibility to obtain referrals whenever required by your insurance plan. We will assist you whenever possible. If you change your Primary Care Physician, you must notify us immediately and obtain a new referral.
- **Co-Payment, Co-Insurance and Deductibles:** You must pay for your Co-Payment at the time of your visit. If your plan has a deductible and/or co-insurance, we will collect a portion at the time of your visit.
- **Non-Covered Services:** Patients are responsible for non-covered services when they are denied by their insurance company.
- **Lab work:** Your physician may order lab work. It is your responsibility to confirm whether the lab work is covered under your insurance plan.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges.

Signature of Patient or Authorized Representative: _____ Date: _____

Print name of Patient or Authorized Representative: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

PHARMACY INFORMATION SHEET

Date: _____ Patient #: _____ Office: _____

Patient Name: _____

Pharmacy Name and Address: _____

_____

Pharmacy Phone Number: _____

MAIL ORDER PHARMACY ONLY

☐ CHECK HERE IF MAIL ORDER INFORMATION IS DIFFERENT FROM THE INFORMATION ABOVE.

If applicable, fill in the following:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Prescription Card Number: _____

Company FAX: _____

HOW DID YOU HEAR ABOUT US?

- ☐ Physician- Specialist
- ☐ Physician- Primary Care Physician/Pediatrician
- ☐ Community Event
- ☐ Internet Search
- ☐ Social Media
- ☐ Word of Mouth
- ☐ TV/Radio
- ☐ Health Insurance
- ☐ Hospital Emergency Room
- ☐ Urgent Care
- ☐ I am a former patient
- ☐ Cairn

Thank you for your collaboration!
Make sure you follow us on our social media
@langfordallergy

EMAIL UPDATES

The Physicians and Staff at Langford Allergy, LLC would like the opportunity to provide you with the latest information, news and messages that can benefit you and your treatment. To better serve you and contact you more efficiently, we ask you to provide us with your e-mail address. Please note that the use of email is intended only for use by Langford Allergy, LLC. Your email will never be sold or shared with any other third parties.

First and Last Name: _____ Date: _____

Email Address: _____

Thank you for your assistance!

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Authorization for Release of Medical Records

Top for office use only.

To: _____

_____

_____

I hereby request that the following medical records be released to Langford Allergy, LLC

- ☐ Progress Notes
- ☐ Phone Notes
- ☐ Skin Testing
- ☐ Phone Records
- ☐ Immunotherapy Prescription
- ☐ Labs

I waive and release any member of previous doctor's staff from any restriction of privilege imposed by law in disclosing or revealing any professional record, observation, or communication.

Name: _____

Date of Birth: _____

_____ _____

Signature *Date*

Relationship to Patient: _____

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