

# COASTAL

ALLERGY & ASTHMA, P.C.

*Specializing in the Treatment of Adult and Pediatric Allergic Disorders*

Bruce D. Finkel, M.D.  
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Monica Rama, M.D.  
Timothy J. Dare, Jr., PA-C

Dear New Patient,

Welcome to our practice. We are delighted you have chosen Coastal Allergy & Asthma, PC for your allergy and/or asthma care. Your appointment is scheduled for:

Day/Date	
Time	AM / PM
Physician	Dr.

Our physicians and staff want to make your visit with us as comfortable as possible and minimize your wait time in our lobby; therefore we have enclosed our new patient information packet. On the day of your appointment, please bring the following with you:

- The attached **forms** completed
- A list of all **medications** you are currently taking
- Your **insurance** card

Feel free to call our office at **912-354-6190** or toll free at **866-273-2849** if you should have any questions or if you need to reschedule this appointment.

Directions to our offices are provided on the back of this letter. Timeliness is important to our office. If you arrive 15 minutes late for your appointment, out of consideration for other scheduled patients, your appointment may be rescheduled for another date.

We look forward to having you as our patient.

Sincerely,

The staff and physicians of Coastal Allergy & Asthma, PC

How Did You Hear About Us...

- Physician Referral, Internet, Newspaper, Television, Radio, Friend/Family, Other

COASTAL ALLERGY & ASTHMA, P.C. Patient Information Form

Date, Appt. Date, New Patient, Former Patient, Doctor

Referring Physician, Phone Number

Reason for Visit/Referral, Date of Onset

Primary Care Physician

Patient's Personal Information, Male, Female

Name, Last, First, MI, DOB, SSN, Marital Status, M, S, W, D

Street Address, City, State, ZIP

Mailing Address, City, State, ZIP

Home Phone, Work Phone

Employer's Name, Address

Occupation, Phone Number, ext.

Guarantor's Personal Information, (Person responsible for bill), Male, Female

Name, Last, First, MI, DOB, SSN, Marital Status, M, S, W, D

Street Address, City, State, ZIP

Mailing Address, City, State, ZIP

Home Phone, Work Phone

Employer's Name, Address

Occupation, Phone Number, ext.

Spouse Information

Name, Address (if different from patient)

DOB, SSN, Home Phone, Work Phone

Employer's Name, Address, Occupation

Insurance Information

Primary Insurance, Group Number, Policy Number

Claims Address, City, State, ZIP

Insured, Patient Relationship to Insured

Insured SSN, Insured DOB, Co-pay \$

Secondary Insurance, Group Number, Policy Number

Claims Address, City, State, ZIP

Insured, Patient Relationship to Insured

Insured SSN, Insured DOB, Co-pay \$

Emergency Contact (Not living in same household), Name

Address, Phone No., Relationship

Authorization to Treat and Release

In connection with my care and treatment I authorize Coastal Allergy & Asthma PC to release to, and receive from, any Doctor, Hospital, Clinic, other Healthcare Provider, or Insurance Carrier any medical records or information relating to my health, including without limitation, any information relating to illness or disease cause, treatment, diagnoses, prognoses, laboratory and/or radiology test and/or procedures, and prescriptions. The forgoing shall include records, and information relating to HIV infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), Mental Illness, and/or use of alcohol or drugs. Your signature below fully authorizes our staff and doctors to perform examinations, diagnostic test and/or treatment, as we may consider it necessary.

I agree to notify Coastal Allergy & Asthma PC of any changes pertaining to my address and/or insurance information.

Signature: (If minor, signature of parent or guardian) Date

Assignment

I authorize direct payment from my Insurance Company to my provider. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred. We will file non-contracted insurance as a courtesy; however, if we have no response from your insurance company within 60 days, the charge(s) will be transferred to your responsibility to pay.

Signature: (If minor, signature of parent or guardian) Date

## Coastal Allergy & Asthma, PC Patient Financial Policy

*Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services.*

### **Payment Policy**

- Payment is due at the time services are rendered unless other arrangements have been made by either you or your insurance company.
- We accept cash, check, Visa, Mastercard, American Express and Discover.
- Co-payments must be paid on the date service is rendered.
- Patients are responsible for their deductible or charges not reimbursed by insurance.
- If the patient is a minor (18 years or younger), the parent or guardian is responsible for payment of the account, accordance with policy outlined above.
- As a courtesy, we will automatically file your insurance claims, therefore will request a copy of your insurance card at the time of each visit.
- For services estimated to cost more that \$200.00, we will accept a minimum payment of \$50.00. Upon request, a short-term payment arrangement can be considered.
- You will receive monthly statements. If your account is not paid within 60 days your account will be considered past due.
- Patients having health insurance will be expected to contact their insurance carrier if there is a delay in payment. Please understand that insurance is a contract between you and your carrier, therefore, you are ultimately responsible for your bill.
- If you have difficulty paying your account, please contact our billing department.
- In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment: there are no exceptions.

### **Referrals**

It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

### **Acknowledgment and Authorization**

I have read, understand and agree to the above policies. I understand the charges not covered by my insurance company, as well as co-payments and deductibles are my responsibility.

I authorize my insurance benefits be paid directly to Coastal Allergy&Asthma PC.

I authorize Coastal Allergy&Asthma PC to release any medical or other information to my insurance company when requested.

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  
(If patient is a minor)

# COASTAL ALLERGY & ASTHMA, P.C.

BRUCE D. FINKEL, M.D.  
505 Eisenhower Drive  
Savannah, GA 31406

BRAD H. GOODMAN, M.D.

MONICA RAMA, M.D.

TIMOTHY J. DARE, PA-C  
(912) 354-6190  
Fax (912) 354-6172

## Medical History

Your Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Referring Physician \_\_\_\_\_

Reason for Visit \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Leading Health Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication Allergies: \_\_\_\_\_  
\_\_\_\_\_

- Symptom Triggers for Hay Fever/Asthma:
- |                                   |                                      |   |
|-----------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Dust     | <input type="checkbox"/> Exercise    | <input type="checkbox"/> Mildew           |
| <input type="checkbox"/> Grass    | <input type="checkbox"/> Cold Air    | <input type="checkbox"/> Weather Changes  |
| <input type="checkbox"/> Perfumes | <input type="checkbox"/> Paint Fumes | <input type="checkbox"/> Tree Pollens     |
| <input type="checkbox"/> Dampness | <input type="checkbox"/> Animal Hair | <input type="checkbox"/> Smoke            |
|                                   |                                      | <input type="checkbox"/> Infections/Colds |

- Check All That Apply to You:
- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Drug Allergy | <input type="checkbox"/> Hay Fever      |
| <input type="checkbox"/> Insect Sting Allergy | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Hives/Swelling |

Have you ever been skin tested?  Yes  No When? \_\_\_\_\_

Have you ever had a breathing test (spirometry)?  Yes  No When? \_\_\_\_\_

Have you received oral/IV steroids in the past six months?  Yes  No

How many school/work days have you missed in the past year? \_\_\_\_\_

Have you taken an antihistamine in the past week?  Yes  No Which antihistamine(s)? \_\_\_\_\_

Social History: Do you smoke?  Yes  No  Cigarettes  Pipe  Cigars How Long? \_\_\_\_\_

Do you regularly consume alcohol?  Yes  No If so, how often? \_\_\_\_\_

Do you drink more than six cups of coffee a day?  Yes  No

Environmental History: Do you have any unusual work exposure?  Yes  No If so, what? \_\_\_\_\_

Do you have central air and heat?  Yes  No

How many pets do you have? \_\_\_\_\_ What kind? \_\_\_\_\_

What type of floors do you have in the bedroom? \_\_\_\_\_

What type of comforter do you have? \_\_\_\_\_

With what are your pillows stuffed? \_\_\_\_\_



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## Asthma History

Are there any medications you would not want your child to receive?  Yes  No

If so, what medication and why? \_\_\_\_\_

At what age did you/your child begin to experience breathing difficulties? \_\_\_\_\_

Have you/your child ever required the use of systemic (IV, IM, oral) steroid such as prednisone, predlone, pediapred and decadron?  Yes  No

If yes, how many times in the last 12 months? \_\_\_\_\_

Have you/your child been admitted to the hospital for asthma?  Yes  No

Pneumonia  Yes  No

Breathing Difficulties  Yes  No

If yes, how many times total? \_\_\_\_\_ How many times in the last year? \_\_\_\_\_

Have you/your child ever been admitted to the Intensive Care Unit for asthma/breathing problems?  Yes  No

If yes, how many times? \_\_\_\_\_ Was assisted mechanical ventilation (intubation) required?  Yes  No

How many times in the last year have you/your child needed to go to an emergency center/immediate medicine clinic? \_\_\_\_\_

What plan do you have for when you/your child is having an asthma attack? \_\_\_\_\_

What medicine do you use? How often? \_\_\_\_\_

Do you have a written asthma action plan based on peak flow readings?  Yes  No

Have you/your child ever received allergy skin testing?  Yes  No

If so, when and for how long? \_\_\_\_\_

Any benefit? \_\_\_\_\_

Do you suspect any allergies in you/your child?  Yes  No

## Asthma Characteristics

Has patient ever experienced the following: Comment on frequency:

Yes  No Cough \_\_\_\_\_  Yes  No Wheeze \_\_\_\_\_

Yes  No Chest Pain \_\_\_\_\_  Yes  No Sleep Disturbance \_\_\_\_\_

Yes  No Frequent School Absences \_\_\_\_\_  Yes  No Limited Physical Activity \_\_\_\_\_

Yes  No Frequent Doctor Visits \_\_\_\_\_  Yes  No Emergency Room Visits \_\_\_\_\_

Yes  No ICU Admissions for Asthma \_\_\_\_\_  Yes  No Cyanotic (Blue) Episodes \_\_\_\_\_

Yes  No Respiratory Arrest \_\_\_\_\_  Yes  No Intubation \_\_\_\_\_

**Review of systems: (Check all that apply to you)**

- |                   |  |  |   |  |
|-------------------|--|--|---|--|
| <b>General:</b>   | <input type="checkbox"/> Fever                 | <input type="checkbox"/> Night Sweats      | <input type="checkbox"/> Chills         | <input type="checkbox"/> Weight Gain                 |
|                   | <input type="checkbox"/> Weight Loss           | <input type="checkbox"/> Fatigue           |   |  |
| <b>Skin:</b>      | <input type="checkbox"/> Rashes                | <input type="checkbox"/> Changing Moles    | <input type="checkbox"/> Itching        | <input type="checkbox"/> Easy Bruising               |
| <b>HEENT:</b>     | <input type="checkbox"/> Itchy Eyes            | <input type="checkbox"/> Runny Nose        | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Red Eyes                    |
|                   | <input type="checkbox"/> Itchy Nose            | <input type="checkbox"/> Ringing in Ears   | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nosebleeds                  |
|                   | <input type="checkbox"/> Vertigo               | <input type="checkbox"/> Mucus in Eye      | <input type="checkbox"/> Sniffling      | <input type="checkbox"/> Migraines                   |
|                   | <input type="checkbox"/> Nasal Polyps          | <input type="checkbox"/> Sore Throats      | <input type="checkbox"/> Hoarseness     | <input type="checkbox"/> Sinus Pain                  |
|                   | <input type="checkbox"/> Overbite              | <input type="checkbox"/> Sneezing          |   |  |
| <b>Heart:</b>     | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Leg Cramps        | <input type="checkbox"/> Palpitations   | <input type="checkbox"/> Hypertension                |
|                   | <input type="checkbox"/> Use 2 or More Pillows | <input type="checkbox"/> Murmur            | <input type="checkbox"/> Leg Swelling   | <input type="checkbox"/> Skipped Heartbeats          |
|                   | <input type="checkbox"/> Fainting              |  |   |  |
| <b>Lungs:</b>     | <input type="checkbox"/> Chest Tightness       | <input type="checkbox"/> Awaken Breathless | <input type="checkbox"/> Cough          | <input type="checkbox"/> Cough Discolored Sputum     |
|                   | <input type="checkbox"/> Sputum Production     | <input type="checkbox"/> Cough Up Blood    |   |  |
| <b>GI:</b>        | <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Vomit Blood       | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Black/tarry Stools          |
|                   | <input type="checkbox"/> Stomach Pain          | <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Mucus in Stool              |
| <b>Skeletal:</b>  | <input type="checkbox"/> Joint Pain            | <input type="checkbox"/> Muscle Weakness   | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Arthritis                   |
|                   | <input type="checkbox"/> Muscle Spasm          | <input type="checkbox"/> Muscle Pain       |   |  |
| <b>Neuro:</b>     | <input type="checkbox"/> Seizure History       | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Incoordination | <input type="checkbox"/> Vertigo                     |
|                   | <input type="checkbox"/> Tingling              | <input type="checkbox"/> Migraine          |   |  |
| <b>Endocrine:</b> | <input type="checkbox"/> Excessive Thirst      | <input type="checkbox"/> Void Frequently   | <input type="checkbox"/> Dry Skin       | <input type="checkbox"/> Recent Weight Changes       |
|                   | <input type="checkbox"/> Eat Frequently        | <input type="checkbox"/> Constipation      |   |  |
| <b>GU:</b>        | <input type="checkbox"/> Burning on Urination  | <input type="checkbox"/> Void at Night     | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Incontinence                |
|                   | <input type="checkbox"/> Hesitancy             | <input type="checkbox"/> Venereal Disease  | <input type="checkbox"/> Kidney Stones  | <input type="checkbox"/> Frequent Bladder Infections |

**For Females Only:**

Number of pregnancies \_\_\_\_\_  
 Date of last menstrual period \_\_\_\_\_  
 Do you have heavy periods? \_\_\_\_\_  
 Have you entered menopause? \_\_\_\_\_

Number of live births \_\_\_\_\_  
 Are periods regular? \_\_\_\_\_  
 Cramping with periods? \_\_\_\_\_  
 Date of last pelvic exam \_\_\_\_\_

# COASTAL ALLERGY & ASTHMA, PC

## NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Policy containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Policy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Policy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Policy Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:
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