

New Patient Information Sheet

Account #: _____
Chart #: _____

New Patient Information

Patient Last name	First Name	MI	Age	Date of Birth	Social Security #	Marital Status	Sex
						M S D W	M F
Home Street address:					Home Phone #: ()		
City:		State:	Zip:	Bus. Phone #: ()			
Referring Physician Name and Address:							
source of referral if not referred by a physician:							

Person Responsible For Payment

Last name	First Name	MI	Date of Birth	Social Security #	Relationship to Patient
Street address:				Home Phone #: ()	
City:		State:	Zip:	Bus. Phone #: ()	
Employer:			Occupation:		
Employer Address:			State:	Zip Code:	

Other than the responsible party, in case of emergency contact:

Last Name	First Name	Relation to Patient	Home Phone #: ()
			Bus. Phone #: ()

Health Insurance Information - Primary Insurance

Insurance Name	Insurance Address	
Member ID #	Policy or Group Number	Relationship to Policy Holder
Medicaid #:		Medicare #:

Health Insurance Information - Secondary Insurance

Insurance Name:	Insurance Address:	
Member ID #	Policy or Group Number	Relationship to Policy Holder

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

I hereby authorize Dr. Daniel Suez to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Dr. Suez all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE _____ DATE _____



Daniel Suez, M.D., Allergy, Asthma & Immunology Clinic, P.A.

FAAAAI, Board Certified in Allergy & Immunology and Diagnostic Laboratory Immunology

OFFICE POLICIES

Please read the following information regarding our office policies. After you have read the information, please sign and return it to the receptionist who will then give you a copy.

PAYMENTS/FEES

All co-pays and balances are due at the time of service. As a courtesy we bill primary and secondary insurance. Notify the office of any insurance changes as soon as possible. If not notified, you will be responsible for the fee. **Note: There is a \$25 returned check fee.** Phone consultation fee will be applicable.

PHONE AND CALLING AFTER HOURS

If you have an emergency or need to talk to the Doctor after our office hours, call our number (972-401-0545) and press "0." This will connect you with our answering service. The Doctor will be paged.

APPOINTMENTS

The receptionist will assist you with making an appointment at either of our facilities. If you have to reschedule or cancel an appointment, please do so as soon as possible. If not cancelled or rescheduled within 24 hours, **there is a \$35 cancellation fee.**

REFERRALS

If your insurance plan requires a referral from your Primary Care Provide (PCP) it is the patient's responsibility to obtain this before your visit. Your insurance will not pay without this referral and payment will be your responsibility. If you do not have your referral or our office has not received it, you will have to reschedule.

OFFICE HOURS *Our office is closed from 12:00 – 1:30 for lunch.

Monday & Wednesday: 7:00 – 4:30
Tuesday & Thursday: 7:00 – 6:00
Friday: 7:00 – 12:30

Patient Signature

Date

1115 Kinwest Parkway, Suite 100, Irving, TX 75063
Phone: 972-401-0545 Fax: 972-401-0614 e-mail: dsuez@dsallergy.com
Website: www.dsallergy.com

Daniel Suez MD, Allergy, Asthma & Immunology Clinic, P.A.

1115 Kinwest Parkway, Suite 100, Irving, TX 75063 Tel: 972-401-0545 Fax: 972-401-0614

PATIENT QUESTIONNAIRE

Please answer the following questions as accurately as possible. This will assist the physician in being best prepared for you on the day of visit.

NAME: _____ AGE: _____ DATE: _____

PERSON COMPLETING THIS QUESTIONNAIRE NAME): _____

RELATIONSHIP TO PATIENT: _____

REFERRING PHYSICIAN (NAME) AND SPECIALTY: _____

(i.e. pediatrician, allergist, general practitioner, etc.)

NAME OF PARENTS (IF MINOR) _____

ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____

HOW LONG HAS THE PATIENT LIVED IN THE PRESENT LOCATION? _____

PREVIOUS PLACE OF RESIDENCE _____

PATIENT'S OCCUPATION _____

DESCRIBE BRIEFLY YOUR /THE PATIENT'S PROBLEM:

EFFECT OF PATIENT'S ILLNESS ON DAILY LIVING:

1) Number of school days missed in the last 12 months (if patient is minor) _____

2) Number of work days missed by patient in last 12 months _____

3) Number of doctor's visits for above symptoms in the last 12 months _____

FAMILY HISTORY

HAS ANY DIRECT FAMILY MEMBER HAD ONE OF THE FOLLOWING?

(including mother, father, sister, brother, son, daughter)

	YES	NO	RELATIONSHIP
ASTHMA	_____	_____	_____
ALLERGIC RHINITIS	_____	_____	_____
SINUSITIS	_____	_____	_____
ECZEMA	_____	_____	_____
HIVES	_____	_____	_____
FOOD ALLERGY	_____	_____	_____

NAME: _____ AGE _____ DATE: _____

ENVIRONMENTAL HISTORY:

TYPE OF DWELLING (House, Apt, Mobile Home) _____

AGE OF DWELLING _____

AIR CONDITIONING TYPE (Central, swamp cooler, window unit) _____

ARE THERE ANY DAMP OR MUSTY PLACES IN THE HOUSE? YES _____ NO _____

WHERE? _____

DOES ANYONE SMOKE AT HOME? YES _____ NO _____ WHO? _____

WHAT KINDS OF PETS DO YOU HAVE? _____

ARE THESE ALLOWED IN THE HOUSE? YES _____ NO _____

ARE THESE ALLOWED IN THE PATIENT'S BEDROOM? YES _____ NO _____

ARE THERE OTHER ANIMALS ON THE PROPERTY? YES _____ NO _____

LIST: _____

PATIENT'S BEDROOM:

WHAT IS THE COMPOSITION OF THE PILLOWS? _____

DO ANY OF THE MATTRESSES, BOXSPRINGS OR PILLOWS HAVE ALLERGY-PROOF COVERS?

YES _____ NO _____

KIND OF FLOOR COVERING IN THE ROOM _____

PAST MEDICAL HISTORY:

OTHER DISEASES FOR WHICH YOU/THE PATIENT HAS BEEN TREATED

1. _____

2. _____

3. _____

OPERATIONS:

TONSILLECTOMY & ADENOIDECTOMY _____ AT WHAT AGE _____

EAR TUBES _____ AT WHAT AGE _____

SINUS SURGERY _____ AT WHAT AGE _____

OTHER (PLEASE NAME) _____

IS THERE ANYTHING ELSE WHICH HAS NOT BEEN MENTIONED, THAT YOU THINK IS SIGNIFICANT IN CONTRIBUTING TO THE PROBLEM? _____

I GIVE DR. DANIEL SUEZ PERMISSION TO INCLUDE THIS INFORMATION AS PART OF THE MEDICAL RECORD.

PATIENT'S/PARENT'S SIGNATURE

DATE