

# Allergy & Asthma Clinic Of Northeast Georgia

## New Patient Information

This information packet includes your pre-admission form and medical history questionnaire. Please download, print and complete all pages, in their entirety and bring them with you to your appointment. This will expedite your admission and allow our doctors and staff to better serve you.

If you have any questions please contact our office at 770 534-0534.

Your Appointment is: Date: \_\_\_\_\_ Time: \_\_\_\_\_

520 Jesse Jewell Parkway - Gainesville, Georgia - 30501  
Office 770 534-0534 [www.aacng.com](http://www.aacng.com)

Allergy & Asthma Clinic of Northeast Georgia  
520 Jesse Jewell Parkway  
Gainesville, Georgia 30501  
(770)-534-0534 www.aacng.com

Account #: \_\_\_\_\_

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

Doctor: \_\_\_\_\_

## Patient Registration

**FOR OFFICE USE ONLY**

### PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

Street or Road Name: \_\_\_\_\_ County of residence: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Widowed Home #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_)-\_\_\_\_\_  
 Married  Divorced Is patient a student?:  Yes  No

Emergency Name (not at your address): \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: (\_\_\_\_)-\_\_\_\_

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

How long employed there: \_\_\_\_\_ Telephone # at work: \_\_\_\_\_

Name of Patient's Primary Care Physician: \_\_\_\_\_

Did your physician refer you to us?  yes  no If yes, please list his/her complete name and address: \_\_\_\_\_

Names of family members that are patients here at this clinic and their relationship to you: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

How long employed there: \_\_\_\_\_ Telephone # at work: \_\_\_\_\_

**GUARANTOR (Person responsible for the bill. Must be the person who signs as guarantor on the following page):**

Guarantor full name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing address: (if different from patient): \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Guarantor's employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's relationship to Guarantor (circle one): Self Spouse Child Other (list): \_\_\_\_\_

Allergy & Asthma Clinic of Northeast Georgia  
520 Jesse Jewell Parkway  
Gainesville, Georgia 30501  
770-534-0534 www.aacng.com

---

**INSURANCE INFORMATION:**

**PRIMARY INSURANCE**

Primary Insurance Company Name: \_\_\_\_\_

Street Address or P.O. Box: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Insured person's full name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address/Phone # of insured person if different from patient: \_\_\_\_\_

---

**SECONDARY INSURANCE**

Secondary Insurance Company Name: \_\_\_\_\_

Street Address or P.O. Box: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Insured person's full name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address/Phone # of insured person if different from patient: \_\_\_\_\_

---

Do you have Medicare?  Yes  No If yes, Medicare #: \_\_\_\_\_

Do you have Medicaid?  Yes  No If yes, Medicaid #: \_\_\_\_\_

(If current Medicaid card isn't furnished at time of service or if you have exceeded the allowed number of doctor's visits per year, you are expected to pay for services rendered. Medicaid patients need to complete the guarantor section on page one.)

**PAYMENT IS EXPECTED AT TIME OF SERVICE. We accept cash, check or credit card.**

If you have insurance coverage, you are required to pay your co-pay or the portion not covered by your insurance company at the time of service. If your insurance company does not respond within 30 days after your claim is filed, payment then becomes your responsibility. If you have any questions, please ask.

---

I authorize release of any information necessary to process claims and direct payment to the Allergy & Asthma Clinic of Northeast Georgia. I understand that I am responsible for ALL charges, regardless of insurance coverage. **IF PATIENT IS A MINOR, FINANCIAL RESPONSIBILITIES LIE WITH THE PARENT/GUARDIAN BRINGING THE CHILD.**

\_\_\_\_\_  
Guarantor Signature (This must be the person listed as guarantor on previous page.) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Michael J. Maloney, M.D.

Donell Ducote, FNP-C, CS

John A. Yarbrough, M.D.

**Medical History Questionnaire**

**Patient Name:** \_\_\_\_\_ **Regular Physician:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Problem to discuss:**

**SYMPTOMS:** *Circle any chronic symptoms you have had.*

**Do not write in this column**

**HEAD AND NECK SYMPTOMS:**

runny nose

stuffy nose

bouts of sneezing

itchy nose or throat or ear canals

post nasal drainage

frequent nosebleeds

sinus headaches    Other headaches

any sinus infections?

itchy, watery eyes

popping in ears

hearing loss

bad taste in mouth or bad breath

medicines you have tried:  
did they help?

**CHEST & LUNG SYMPTOMS:**

shortness of breath

chest tightness

wheezing

“rattles in chest”

cough

sputum coughed up? \_\_\_\_\_ color? \_\_\_\_\_

Have you had asthma before?

Michael J. Maloney, M.D.

Donell Ducote, FNP-C, CS

John A. Yarbrough, M.D.

**Medical History Questionnaire**

**GASTROINTESTINAL SYMPTOMS:**

frequent vomiting or diarrhea

abdominal or stomach pain

heartburn or ulcer pain

poor appetite or excessive appetite

**SKIN SYMPTOMS:**

eczema

hives

itching of skin

other rash?    where? \_\_\_\_\_  
                         when? \_\_\_\_\_

**Do not write in this column**

**List ALL MEDICATIONS you are currently taking (prescription or not including aspirin, vitamins, herbs, etc.)**

**Inhalants** that you think make your most troublesome symptoms worse:

household dust    feathers    animal dander

mold            mildew            damp areas

tree pollens    grass cuttings    leaves    hay

colognes or perfumes    smoke

**Other factors** that increase your symptoms:

sunlight    exercise    fatigue

change in temperature or humidity

**Do not write in this column**

Michael J. Maloney, M.D.

Donell Ducote, FNP-C, CS

John A. Yarbrough, M.D.

**Medical History Questionnaire**

**Do not write in this column**

**ENVIRONMENTAL HISTORY:**

Circle or fill-in the answers that apply to your home:

How long have you lived in your home? \_\_\_\_\_

It is made of: brick wood block Other: \_\_\_\_\_

It is a: house / apartment / mobile home that is \_\_\_\_\_ years old

Type of mattress: foam / innerspring / water bed

Type of pillow: foam / feather / synthetic other: \_\_\_\_\_

Pillow is \_\_\_\_\_ years old. Mattress is \_\_\_\_\_ years old.

Floors are mostly: carpet / wood / linoleum / other

House is generally: dry / dusty / moist / musty

Air conditioning is: central / window units / not installed

Heating system: electric / gas / oil / wood / kerosene

Basement is: damp / very wet / dry / do not have one

Change heat/air system filter every \_\_\_\_\_ months.

Any pets? Yes / No Type: \_\_\_\_\_ Indoors? Yes / No

Any smokers in the home? Yes/no Who? \_\_\_\_\_

How many people in household? \_\_\_\_\_

Anything unusual or remarkable about this home? \_\_\_\_\_

**FOOD REACTIONS:**

Describe any reactions to foods:

Are you on a special diet?

**DRUG REACTIONS:**

Describe any reactions to medications:

(i.e. penicillin, codeine, etc.) When did the reaction(s) occur?

Michael J. Maloney, M.D.

Donell Ducote, FNP-C, CS

John A. Yarbrough, M.D.

**Medical History Questionnaire**

**INSECT ALLERGIES:**

Describe any reaction to an insect sting and how it was treated:

**Do not write in this column**

**PAST MEDICAL HISTORY:**

Have you ever been seen by an allergist or an ear, nose and throat doctor? When?

Were you on allergy shots?

Any other health problems, hospitalizations, or chronic illnesses?

**FAMILY HISTORY:**

Describe allergic symptoms in family members:  
(i.e., hay fever, asthma, sinus problems)

Father:

Mother:

Brother:

Sister:

Sons:

Daughters:

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

Work Environment: \_\_\_\_\_

Tobacco use: \_\_\_\_\_

Hobbies? \_\_\_\_\_

**ANY OTHER PROBLEMS TO DISCUSS?**

