

JOHN OVERHOLT, M.D. / J. MICHAEL NORVELL M.D.

Today's Date: _____

E-mail Address _____

PATIENT INFORMATION

Physician: _____ Chart#: _____

Name: _____ M or F

Address: _____ LAST FIRST MIDDLE City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____

Age: _____ Date of Birth: _____ Social Security #: _____

Patient Employer: _____ Employer Address: _____

Marital Status S M W D Spouse's Name: _____

Spouse's Date of Birth: _____ Spouse's Employer: _____

Employer's Address: _____ Work Phone: () _____

Emergency Contact: _____ Phone: () _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: () _____

Primary Care Physician: _____ Phone: () _____

Source of Referral: _____

RESPONSIBLE PARTY INFORMATION

(If you are 18 or over you are considered to be the responsible party. If the patient is a minor, please fill in the following information completely.)

Relation to Patient: Parent Guardian

Father's Name: _____ LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Social Security #: _____ Date of Birth: _____

Employer: _____ Work Phone: () _____

Relation to Patient: Parent Guardian

Mother's Name: _____ LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Social Security #: _____ Date of Birth: _____

Employer: _____ Work Phone: () _____

INSURANCE POLICY HOLDER INFORMATION

Primary Insurance Name: _____ Primary Insurance Phone: () _____ Effective Date: _____

ID Number: _____ Group Number: _____ Group Name: _____

Relation to Patient: Self Spouse Parent Guardian Champus Coverage/Branch Name: _____

Name: _____ LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____

Secondary insurance Name: _____ Effective Date: _____

ID Number: _____ Group Number: _____ Group Name: _____

Relation to Patient: Self Spouse Parent Guardian Champus Coverage/Branch Name: _____

Name: _____ LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____

FOR OFFICE USE ONLY

Provider Requested: _____ Scheduled With: _____

Appointment Date: _____ Time: _____ Location: _____

Symptoms: _____

Medications: _____

Date _____

Chart# _____

JOHN P. OVERHOLT, M.D. / J. MICHAEL NORVELL M.D.

PATIENT'S NAME: _____ PRIMARY CARE PHYSICIAN _____

Age _____ DOB: _____ REFERRING PROVIDER (if any) _____

GENDER: ___ Male ___ Female MARITAL STATUS: ___ Single ___ Married ___ Divorced ___ Widowed

CHIEF COMPLAINT: (please briefly describe your symptoms in the space below)

ALLERGIC HISTORY: (Please mark any that apply to you. This information will help us understand why you came to see us.)

NOSE and THROAT

Itchy nose _____
Sneezing _____
Runny nose _____
Stuffy nose _____
Snoring _____
Decreased smell _____
Headache _____
Post nasal drainage _____
Drainage cough _____
Hoarseness _____
Sinus infection _____

EYES and EARS

Itchy eyes _____
Red eyes _____
Watery eyes _____
Eyes swelling _____
Blocked ears _____
Ear popping _____
Ear infections _____
Hearing difficulty _____

CHEST

Chest cough. _____
Wheeze _____
Short of breath _____
Chest tightness _____
Smothering _____
Chest infections _____

SKIN

Hives _____
Eczema _____
Itching _____
Swelling _____

FOODS: (please describe any food reactions)

FOR OFFICIAL USE ONLY:

Have you used:

Nasal steroid sprays Y N
Effective Y N Somewhat
Antihistamines Y N
Effective Y N Somewhat
Antibiotics Y N
Name _____

How many times in the past year? _____

Seasons you feel sick: Summer Spring Winter Fall

Seasons you feel well: Summer Spring Winter Fall

ASTHMA:

Prednisone or oral corticosteroids used in the last year:

of Doctor/ER/or Hospital visits for asthma in the last year:

How often do you awake at night with asthma symptoms?

How often are you using your beta agonist (Albuterol etc)?

Provider _____ Date _____

TOTAL=

Name: _____ Date: _____ Chart# _____

Please mark any that cause an increase in your symptoms:

<u>ALLERGENS</u>	<u>IRRITANTS</u>	<u>WEATHER CHANGES</u>
Mowed grass _____	Smoke _____	Windy days _____
House dust _____	Outside dust _____	Cold fronts _____
Cats _____	Odors _____	Temperature changes _____
Dogs _____	Perfumes _____	Damp weather _____
Mold _____	Paint _____	
Musty places _____	Fumes _____	
Dead leaves _____	Hair spray _____	
Hay _____	Soaps _____	
Pollens _____	Detergents _____	

HOME ENVIRONMENTAL SURVEY: (Please check all that apply)

What type of heating/cooling system do you have?
Central air _____ Radiant _____ Wood _____ Kerosene/Oil _____ Ceiling Fan _____

Does anyone at home smoke? Yes _____ No _____

Do you have pets? Yes _____ No _____
If yes, what kind: Indoor _____ Outdoor - _____

Do you have carpet in your bedroom? Yes _____ No _____

Do you sleep with stuffed animals? Yes _____ No _____

Type of Dwelling: _____ House _____ Age _____ How long have you lived here _____
_____ Apartment _____ How long have you lived here _____
_____ Mobile Home _____ How long have you lived here _____

Do you have visible mold in you home? Yes _____ No _____ If yes, where _____

Have you ever had water damage? _____

Are you already using allergy control measures? _____ If so, what? _____

REVIEW OF SYSTEMS: (Please mark any that apply to you.) (Provider told pt to discuss any abnormalities with PCP _____)

<u>GENERAL</u>	<u>JOINT AND MUSCLES</u>	<u>HEADACHES:</u>
Appetite change _____	Joint pain _____	Complete this section only if you have problems frequent headaches.
Weight change _____	Joint swelling _____	
Fatigue _____	Muscle pain _____	Do you have headaches associated with your nasal and sinus symptoms? Yes _____ No _____
Fever _____	Weakness _____	
Chills _____	Backache _____	If yes, complete the following. If no, skip this section.
Sweats _____	<u>ENDOCRINE</u>	
<u>URINARY TRACT</u>	Heat/cold sensitive _____	(Indicate the symptoms you have)
Urinary difficulty _____	Excessive thirst _____	Location (frontal, top, back, cheeks, temples)
<u>ABDOMEN</u>	Excessive hunger _____	Other areas _____
Heart burn _____	Excessive urination _____	Frequency _____ per week or _____ per month
Chronic diarrhea _____	Burning in feet _____	Duration _____ minutes _____ hours _____ days
Constipation _____	Irregular menses _____	Character (throbbing, steady, sharp, dull)
		Relief (e.g., medications, sleep, etc) _____

SLEEP/SNORING

Do you snore? Y N _____ Aggravating factors: (Stress, infection, light noise, etc)

Have you ever been told you stopped breathing while asleep? Y N _____

Is your sleep restful? Y N _____

Does sleepiness interfere with your work? Y N _____

Do you nap? Y N _____

How many hours do you sleep at night? _____

Do you have a regular bedtime? Y N _____

Name: _____ Date: _____ Chart# _____

PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist before? ____ Yes ____ No If so, when? _____
Do you have skin test results? ____ Yes ____ No
(If so, please bring skin test results to the office)
Have you ever been on allergy shots? ____ Yes ____ No If so, are you still taking them? ____ Yes ____ No
If not, approximately how long did you take them? _____ When did you quit? _____

PREVIOUS X-RAYS:

Have you had a CT scan of your sinuses? ____ Yes ____ No When? _____

PAST MEDICAL HISTORY:

List all hospitalizations and surgeries in order of most recent first.
(Diabetes, high blood pressure, heart problems, etc)

1. _____ YR _____
2. _____ YR _____
3. _____ YR _____
4. _____ YR _____
5. _____ YR _____
6. _____ YR _____
7. _____ YR _____
8. _____ YR _____

MEDICAL ILLNESSES:

Please list ALL significant medical problems such as

1. _____ YR _____
2. _____ YR _____
3. _____ YR _____
4. _____ YR _____
5. _____ YR _____
6. _____ YR _____
7. _____ YR _____
8. _____ YR _____

MEDICATIONS:

Please list current medications you take for your allergy symptoms.

MEDICATIONS:

Please list all other medications you take.

What allergy medications have you tried in the past?

Why did you stop using them?

Cost ____ Did not help ____ Side effects ____ Other ____

Cost ____ Did not help ____ Side effects ____ Other ____

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Cost ____ Did not help ____ Side effects ____ Other ____

DRUG ALLERGIES: Please list any drug allergy, and describe your reaction.

1. Penicillin Y N Reaction: _____
2. Sulfa Y N Reaction: _____
3. Asprin Y N Reaction: _____
4. Other: _____ Reaction: _____
5. Other: _____ Reaction: _____

Name: _____ Date: _____ Chart# _____

FAMILY HISTORY:

(Please mark any that apply to blood relatives)

	Mother	Father	Sister	Brother	Children	Others
Asthma	()	()	()	()	()	()
Hayfever	()	()	()	()	()	()
Sinus problems	()	()	()	()	()	()
immune Deficiency	()	()	()	()	()	()
Cystic Fibrosis	()	()	()	()	()	()
Hives	()	()	()	()	()	()
Eczema	()	()	()	()	()	()
Food allergy	()	()	()	()	()	()

SOCIAL HISTORY:

How many people are living at home? _____

Smoking History

Do you currently smoke? ____ Yes ____ No Have you ever smoked? ____ Yes ____ No

How many years have you smoked? _____

How many packs per day? _____

Have you ever quit as long as 6 months? (Please explain) _____

If you have smoked in the past, what year did you stop smoking? _____

How many years did you smoke and how much? _____

Recreation

Please list your favorite hobbies: _____

Employment

Where are you employed (or attend school)? _____

Job Description? _____

Anything at work or school bother your allergies? _____

Number of days missed from work/school per year because of allergy, sinus or asthma problems? _____

If patient is child, does he/she attend day care? ____ Yes ____ No

If yes, how many days per week? _____

ALLERGY & ASTHMA ASSOCIATES
DIRECTIONS TO OUR OFFICES

COLUMBIA: 1407 Hatcher Lane PH#: 931-381-0920

From the corner of Trotwood and James Campbell Blvd. (where Maury Regional Hospital is located) you will stay east on James Campbell. Turn left on Hatcher Lane (first street past intersection). We are located on the corner of Hatcher Lane and Wedgewood. You will turn left on Wedgewood and take an immediate right into our parking lot. You will enter our office from the rear of the building. **There is no handicap accessibility at this location. If you need handicap accessibility, you will need to be seen at our Spring Hill location.**

FRANKLIN: 400 Sugartree Lane, Ste 100 PH#: 615-595-6673

I-65 exit 65 (Hwy 96-Murfreesboro Rd) turn toward Franklin. Go to the 4th traffic light and turn left on Sugartree Lane. Turn immediately to the right. Our office is the corner office directly behind BanCorp South.

CENTENNIAL/NASHVILLE: 2400 Patterson St., Ste 104 PH#: 615-574-6045

We are located at Centennial Hospital in the Physician's Park Building. You can enter the parking lot from the 23rd Avenue Side. Entrance is the same for the hospital visitors with physician's offices being on the left when entering the parking garage. If you wish to park out front of the building, go mid way on Patterson and you will see the 2400 building. Pull in and park in the open parking lot. Take the elevator to the 1st floor

HENDERSONVILLE: 165 Indian Lake Blvd., Ste 109 PH#: 615-822-0858

Take Vietnam Veterans Blvd to Indian Lake Blvd, exit 7. Go right on Indian Lake Blvd until you come to 165 Indian Lake Blvd. From Gallatin Rd you will turn left onto Indian Lake Blvd. Go north on Indian Lake Blvd until you come to 165 Indian Lake Blvd. Our office is located next door to Demo's restaurant. It is on the side of the L-shaped building and does not face Indian Lake Blvd.

SPRING HILL: 5073 Columbia Pk., Ste 230 PH#:615-302-0447

From Nashville: I-65S to 1-840. Take 1-840 towards Franklin. Road dead ends at Hwy 31S. Turn left on 31S. Office is approximately 5 miles on the right. Spring Hill Medical Plaza in front of Lowe's.

From Columbia: Take 31 toward Franklin.

From Franklin: Take 31S toward Columbia. Our office is about 11 miles from intersection of Mack Hatcher Pkwy and 31 in Franklin,

PLEASE READ IMMEDIATELY

Medicine Restrictions Prior to Skin Testing/First visit

DRUG NAME	GENERIC NAME	Do Not Take For:
Alaver/Claritin/Claritin D/Clarinet	Loratadine	7 days
Allegra/Allegra D	Fexofenadine	7 days
Antivert	Meclizine	5 days
Astelin Nasal Spray	Azelastine	2 days
Atarax/Vistaril	Hydroxyzine	7 days
Axid	Nizatidine	2 days
Benadryl	Diphenhydramine	2 days
Broves	Brompheniramine	2 days
Pediox	Chlorpheniramine	2 days
Periactin	Cyproheptadine	2 days
Phenergan	Promethazine	2 days
Tavist	Clemastine	2 days
Zyrtec./Zyrtec D	Cetirizine	7 days

- All other prescriptions and over the counter antihistamines, cough, cold, and sleep medications - Do not take for two days
- The following medications will not interfere with skin testing and patients should continue taking as prescribed: antibiotics, nasal steroid sprays, asthma medications, decongestants, blood pressure medication, and thyroid medication.
- If you have any questions on any medications which may interfere with testing, please call our office

INSURANCE AUTHORIZATION AND ASSIGNMENT

Chart# _____

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. I understand that I am responsible for any amount not covered by my insurance.

I authorize the release of any medical information necessary to process insurance claims filed on my behalf or on behalf of my dependents.

Signature: _____ Date _____

I authorize payment of medical benefits to be made directly to the supplier or physician for services rendered.

Signature: _____ Date _____

I request that payment of authorized MediCare benefits be made either to me or on my behalf to John P. Overholt, MD for services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date _____

I request that payment of authorized Medigap benefits be made on my behalf to John P. Overholt, M.D. for services furnished me by that physician I supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits.

Signature: _____ Date _____

ALLERGY AND ASTHMA ASSOCIATES OF MIDDLE TENNESSEE
PATIENT ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the Notice of Privacy Practices of John P. Overholt, M.D., Allergy Associates, P.A.. I understand that this office is permitted by federal privacy laws to make uses and disclosures of my health information for purposes of treatment, payment, and health care operations. I understand that this office may contact me to provide appointment reminders, and information about treatment alternatives and other health related benefits and services that may be of interest to me.

I understand that this office may disclose my protected health information: (1) to public health or legal authorities charged with preventing or controlling disease, injury, or disability; (2) to public authorities as required by law to report child abuse or neglect; (3) to the FDA with respect to adverse events involving food, supplements, products and product defects, or post-marketing surveillance information; (4) to governmental authorities if authorized by law and necessary to prevent serious harm to me or to others; (5) to appropriate health oversight agencies or for health oversight activities; (6) in the course of a judicial or administrative proceeding as required by law, or as directed by court order, administrative tribunal, subpoena, discovery request or other lawful process; (7) for law enforcement purposes as required by law; (8) to funeral directors or coroners consistent with applicable law; (9) to organ procurement organizations or other applicable entities for the purpose of donation and transplant; (10) to researchers for IRB approved research; (11) to prevent or lessen a serious, imminent threat to the health or safety of others; (12) for specialized government functions as required by law such as for national security or public assistance purposes; (13) to a correctional institution (if applicable) necessary for the health and safety of myself and others; (14) as necessary to comply with Workers Compensation laws.

I understand that this office may make the following uses and disclosures of my protected health information unless I express my objection to such disclosures on the Acknowledgment:

1. To notify, or assist in notifying, a family member, personal representative, or other person responsible for my care, about my location, and about my general condition, or my death.

Agree _____ Object _____

2. To provide health information to a family member, other relative, close personal friend, or any other person identified by me that is relevant to that person's involvement in my care or in payment for such care. I understand that, even if I object to such disclosures, this office may make such disclosures if necessary in an emergency.

Agree _____ Object _____

3. To provide health information to assist in my care or for identification purposes in the event of a disaster.

Agree _____ Object _____

I understand that other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with my written authorization which I may revoke except to the extent information or action has already been taken in reliance on my prior authorization.

Patient Name (Please Print)

Chart Number

Signature of Patient or Parent/Guardian if Minor

Date