

400 Sugartree Lane Suite 100 Franklin, TN 37064 (615) 595-6673	Spring Hill Medical Plaza 5073 Columbia Pike, Suite 230 Spring Hill, TN 37174 (615) 595-6673	1501 Hatcher Lane Columbia, TN 38401 (931) 381-0920	165 Indian Lake Blvd., Suite 109 Hendersonville, TN 37075 (615) 822-0858	95 White Bridge Road (Cavalier Building) Suite 400 Nashville, TN 37205 (615) 574-6045
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Dear: _____

Date: _____

I am delighted you have chosen our office for your allergy care. This letter is to confirm your appointment on _____ at _____. Your appointment has been scheduled at our _____ office. In addition, we would like to share some information to prepare you for your first visit to our office.

QUESTIONNAIRE:

Please take a few minutes to answer the enclosed list of questions. We greatly appreciate your bringing the completed questionnaire with you to your first visit.

WHAT TO EXPECT ON YOUR FIRST VISIT:

Please arrive at our office at least 15 minutes prior to your appointment time. Your first appointment will take approximately 2 hours. During this time, I will take a careful medical history and perform a thorough exam. If your situation indicates the need, allergy skin testing will also be performed. I will then meet with you to discuss my findings and make treatment recommendations.

Please avoid wearing perfumes, cologne, after-shave, body lotions, bath oils or body creams the day of your appointment.

Patients 17 years of age or younger are considered minors and require a parent or guardian to accompany them to the first appointment to authorize treatment.

If this is your child's appointment, and it is necessary to bring other children with you, we ask that you arrange for another adult to accompany you. We find children do not like to be left alone while being skin tested.

REFERRALS:

Many patients are now required to obtain referrals or authorizations from their primary care physician (PCP) before receiving treatment or services from a specialist. It is important to get a referral or authorization from your PCP before coming in for your appointment.

MEDICATIONS:

Some medications can interfere with allergy skin testing. In order for us to obtain the most accurate results, please see the enclosed guidelines for temporarily discontinuing these medications so that you may be skin tested at our appointment if necessary. If you have any other questions regarding drug restrictions or any medications we have not specifically mentioned - please contact our office.

DIRECTIONS TO OUR OFFICE:

We have enclosed directions to our offices. If you have any questions about our office location or find you will be unable to keep your appointment; please feel free to call.

We look forward to getting to know you and helping you with your health care needs!

With warmest regards,

Dr. John Overholt & Dr. J. Michael Norvell

Board Certified Allergy & Immunology

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: _____

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

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

Employer: _____ Work Phone: () _____

Relation to Patient: Parent Guardian

Mother's Name: _____

Address: _____ LAST FIRST MIDDLE 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: _____

Address: _____ LAST FIRST MIDDLE 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: _____

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

Social Security #: _____ Date of Birth: _____

FOR OFFICE USE ONLY

Provider Requested: _____ Scheduled With: _____

Appointment Date: _____ Time: _____ Location: _____

Symptoms: _____

Medications: _____

JO-14

Date _____

Chart# _____

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.)

<u>NOSE and THROAT</u>	<u>EYES and EARS</u>	<u>CHEST</u>	<u>SKIN</u>
Itchy nose _____	Itchy eyes _____	Chest cough. _____	Hives _____
Sneezing _____	Red eyes _____	Wheeze _____	Eczema _____
Runny nose _____	Watery eyes _____	Short of breath _____	Itching _____
Stuffy nose _____	Eyes swelling _____	Chest tightness _____	Swelling _____
Snoring _____	Blocked ears _____	Smothering _____	
Decreased smell _____	Ear popping _____	Chest infections _____	
Headache _____	Ear infections _____		
Post nasal drainage _____	Hearing difficulty _____		
Drainage cough _____			
Hoarseness _____			
Sinus infection _____			

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:

ALLERGENS

Mowed grass _____
House dust _____
Cats _____
Dogs _____
Mold _____
Musty places _____
Dead leaves _____
Hay _____
Pollens _____

IRRITANTS

Smoke _____
Outside dust _____
Odors _____
Perfumes _____
Paint _____
Fumes _____
Hair spray _____
Soaps _____
Detergents _____

WEATHER CHANGES

Windy days _____
Cold fronts _____
Temperature changes _____
Damp weather _____

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? ___ Dog ___ Cat other _____
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 your 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 ___)

GENERAL

Appetite change _____
Weight change _____
Fatigue _____
Fever _____
Chills _____
Sweats _____

JOINT AND MUSCLES

Joint pain _____
Joint swelling _____
Muscle pain _____
Weakness _____
Backache _____

HEADACHES:

Complete this section only if you have problems frequent headaches.

Do you have headaches associated with your nasal and sinus symptoms? ___ Yes ___ No

If yes, complete the following. If no, skip this section.

URINARY TRACT

Urinary difficulty _____

Heat/cold sensitive _____

Excessive thirst _____

(Indicate the symptoms you have)

ABDOMEN

Heart burn _____

Excessive hunger _____

Excessive urination _____

Location (frontal, top, back, cheeks, temples)

Chronic diarrhea _____

Burning in feet _____

Other areas _____

Constipation _____

Irregular menses _____

Frequency ___ per week or ___ per month

Duration ___ minutes ___ hours ___ days

Character (throbbing, steady, sharp, dull)

Relief (e.g., medications, sleep, etc) _____

SLEEP/SNORING

Do you snore? Y N

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

Aggravating factors: (Stress, infection, light noise, etc)

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 ____
Cost ____ Did not help ____ Side effects ____ Other ____
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. Aspirin 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	()	()	()	()	()	()
Hay Fever	()	()	()	()	()	()
Sinus problems	()	()	()	()	()	()
immune Deficiency	()	()	()	()	()	()
Cystic Fibrosis	()	()	()	()	()	()
Hives	()	()	()	()	()	()
Eczema	()	()	()	()	()	()
Food allergy	()	()	()	()	()	()
Drug 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: 1501 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.

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.

WHITE BRIDGE/NASHVILLE: Cavalier Building 95 White Bridge Road, Suite 400 PH# 615-574-6045

From East: Take I-40 West towards Memphis. Take the White Bridge Road exit. Turn left on White Bridge Road. We will be approximately 1 1/2 miles down on the right. We are across from Target and the Vocational School.

From South: Take I-65 North. Take the I-440 loop West towards Memphis. I-440 will merge with I-40 West. Take the White Bridge Road exit. You will turn left off White Bridge Road. We are approximately 1 1/2 miles on the right across from the Vocational School and Target.

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	3 days
Allegra/Allegra D	Fexofenadine	3 days
Antivert	Meclizine	3 days
Astelin Nasal Spray	Azelastine	2 days
Atarax/Vistaril	Hydroxyzine	2 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	3 days
Xyzal	Levocetirizine Dihydrochloride	3 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 _____

