Patient Registration Form

Galveston Physical Medicine
2724 61st #5
Galveston, Texas 77551
Office: 409-744-9355 • Fax: 409-744-9356

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

S.S.N.: _____ Date of Birth: _____ Age: _____

Gender: Male Female Email Address: _____

Marital Status: Married Divorced Single Widowed

Referring Physician: _____ Reason for your visit? _____

Phone: ( ) _____

Address: _____
Street City State Zip Code

Employer or School: _____ Address: _____

Emergency Contact: _____ Relation: _____ Phone: ( )_____

Spouse's Name: _____ S.S.N.: _____

Spouse's Date of Birth: _____ Employer: _____

Spouse's Phone: ( ) _____ Are you insured under their policy? Yes No

Responsible Party Name and Address (Under 18):

Relation to Patient: _____

Date of Birth: _____ Employer: _____ Phone: ( ) _____

Health/Medical Insurance Yes No Self-Pay

PATIENT INSURANCE INFORMATION TO BE COMPLETED ON PATIENT INSURANCE FORM ATTACHED

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

Signature: _____ Date: _____

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ALLERGY INTAKE & CONSENT FORM

Name:_____ DOB: _____

Date of Visit:_____

Do you suffer from allergies? □YES □NO

If yes, which seasons: □SPRING □SUMMER □FALL □WINTER □ALL YEAR

If yes, which of the following symptoms do you typically have:

- ❑ SNEEZING
- ❑ ITCHY AND/OR WATERY EYES
- ❑ SCRATCHY THROAT
- ❑ POST NASAL DRIP
- ❑ JOINT PAIN
- ❑ ITCHY DRY SKIN
- ❑ CONGESTION
- ❑ CHRONIC COUGH
- ❑ RESTLESSNESS
- ❑ HIVES
- ❑ RUNNY NOSE

OTHER:_____

How long have you had these symptoms? _____years _____months

When do you typically experience them the most:

- ❑ MORNING
- ❑ NIGHT
- ❑ ALL DAY

Do you frequently get sinus infections, colds, the flu, or a runny nose? □YES □NO

Have you been diagnosed with Asthma? □YES □NO

If YES, is it controlled? □YES □NO

Do you take any antihistamine medication to control these symptoms? If YES, please list them below and the date last taken: _____

Please list **ALL MEDICATIONS** you are currently taking, and the last date taken:

_____

Are you pregnant? □YES □NO

If no, are you planning on becoming pregnant within the next year? □YES □NO

Are you HIV positive or have AIDS? □YES □NO

Are you taking any Beta Blocker Medications? □YES □NO If yes, which one:_____

Are you taking any Antibiotic Medications? □YES □NO If yes, which one:_____

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Do you have any Auto Immune Diseases? □YES □NO If **yes**, which one:_____

Have you been Allergy Tested in the last 12 months? □YES □NO

If **YES**, are you on immunotherapy? □YES □NO

Are you planning on relocating within the next 12 months? □YES □NO

Have you ever had a life-threatening allergic reaction that needed emergency medical attention?

□YES □NO

Do you have any known food allergies? □YES □NO

If **YES**, which ones? _____

Do you have Dermatographism*? □YES □ NO

Dermatographism is a common benign skin condition which results in a localized hive-like reaction when the skin is scratched or when the skin is exposed to pressure or rubbing

CONSENTS:

By signing below, I am stating that:

- I authorize Galveston Physical Medicine and staff to perform diagnostic allergy testing and administer immunotherapy injections that my healthcare provider considers reasonable and medically necessary.
- I understand that my insurance has certain guidelines for billing allergy skin tests and immunotherapy procedures and my insurance will be billed on dates of service that I am not in the provider's office.
- I consent to the understanding of the immunology process and would like to proceed.
- The opportunity has been provided for me to ask questions regarding the immunotherapy process and the potential side effects.

I acknowledge that I have stopped ALL antihistamines 5 days prior to this testing as they may interfere with test results □YES □NO

Patient Signature: _____ Date _____

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ALLERGY HISTORY

Patient Name _____ Date. _____

Patient Number _____ Age _____ M/F

Branson Allergy Symptom Evaluation™ (BASE)

COMPLAINTS:

Please circle the appropriate number 0 to 3 according to severity:

0 = absent (no symptoms evident)
1 = mild (symptoms present, but minimal awareness),
2 = moderate (tolerable)
3 = severe

Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Itching ears	0	1	2	3
Watery eyes	0	1	2	3	Sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Sensitivity to pet hair	0	1	2	3
Cough	0	1	2	3	Itchy throat	0	1	2	3
Wheezing	0	1	2	3	Sinus pressure	0	1	2	3
Difficulty breathing	0	1	2	3	Sinus pain	0	1	2	3

Other symptoms causing you problems?

_____

MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never 1 = occasionally (several times a month or less) 2 = frequently (several times a week)
3 = daily

Antihistamines	0	1	2	3	Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids	0	1	2	3	Asthma medication (Inhaler, Singulair, Advair)	0	1	2	3
Eye drops	0	1	2	3	Other allergy-related medications _____				

Does any medication give you complete relief of symptoms? _____.

GENERAL ALLERGY HISTORY:

How many months of the year do you have allergies? _____ How many years? _____
In what season are they worse (check all that apply): O Spring O Summer O Fall O Winter
Have you been allergy tested before? O Yes O No
If yes, which type: O Skin prick/Puncture O Blood draw
Have you previously received allergy shots? _____Allergy drops?_____ If yes, when? _____
Do you smoke or use tobacco products? _____
List any animals you have in or around the home _____
Who else in your family has allergies? _____

PROVIDER ONLY

RAW SCORE: _____/25

SCORE: _____ (Multiply raw score by 4)

0-25 = MILD 26-50=SIGNIFICANT
51-100 = SEVERE 100+= VERY SEVERE

PATIENT DETAILED INFORMATION FORM

PATIENT NAME _____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

Do You Have Diabetes (Yes or No) _____ Peripheral Vascular Disease (PVD) (Yes or No) _____

Have You Ever had Covid (Yes or No) _____ PLEASE BE SURE TO SIGN AT THE BOTTOM OF THIS

What is the Name of Your Health Insurance Company? _____

AUTONOMIC NERVOUS SYSTEM DYSFUNCTION (ANSD)	6 Months	Today
Blurred Vision		
Elevated Blood Sugar		
Extreme Thirst		
Frequent Urination		
Fatigue (Tiredness)		
Heartburn		
Increased Hunger		
Nausea		
Numbness & Tingling in Hands or Feet		
Vomiting		
Burning Sensations		
Difficulty Digesting Food		
Dizziness or Fainting		
Exercise Intolerance		
Sexual Difficulties		
Sweat Abnormalities		
Tingling Hands & Feet		
Urinary Problems		
CARDIOMETABOLIC RISK (CMR)	6 Months	Today
Headaches		
Dizziness		
Swelling of Ankles		

ENDOTHELIAL DYSFUNCTION (ENDOD)	6 Months	Today
Angina (severe chest pain, often spreading to shoulder, arm, back, neck, or jaw)		
Chest Pain that goes away with rest		
Heartburn		
Pain In Calves		
Shortness of Breath		
Stroke		
TIA (mini stroke)		
INSULIN RESISTANCE (IR)	6 Months	Today
Blurred Vision		
Elevated Blood Sugar		
Extreme Thirst		
Fatigue (Tiredness)		
Increased Hunger		
CARDIOMETABOLIC AUTONOMIC NEUROPATHY (CAN)	6 Months	Today
Blurred Vision		
Cold, Clammy, Pale Skin		
Depression		
Dizziness or Lightheadedness		
Thirst		
Fainting		
Fatigue (Tiredness)		
Lack of Concentration		

SMALL FIBER SENSORY NEUROPATHY (SFN)	6 Months	Today		Lack of Energy		
Burning Sensations				Nausea		
Painful Contact With Socks or Bed Sheets				Rapid, Shallow Breathing		
Pebble or Sand like Sensation In Shoes						
Stabbing or Electrical Shock Sensation						
Pins And Needles Sensation In Feet						

PLETHYSMOGRAPHY CARDIOVASCULAR DISEASE (PTG CVD)	6 Months	Today				
Blood clot in a vein (Venous Thrombosis)						
Heart Attack						
Irregular heartbeat, too fast/slow (Atrial Fibrillation)						
Stroke						

I authorize the release of my test results, with all identifiable information removed, to Health Profit Solutions, Inc. and PECE, LLC to be used in aggregating data which allows for improving the effectiveness of testing and treatment. The test results will not have any impact on my care, treatment or my cost of care or treatment.

Patient Signature:_____Date Completed:_____ Patient

Printed Name: _____