Sweetwater Medical Associates
16651 Southwest Freeway Suite 100
Sugar Land, Texas 77479
(281) 494-4900 Fax: (281) 494-4905

Jonathon B. Shaffer, M.D.
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Welcome to Sweetwater Medical Associates, PLLC

Dear Esteemed Patient,

We are very happy to welcome you to our practice and proud that you chose us to care for your medical needs. We will strive to make each and every visit a satisfying experience. For us to be successful in this endeavor we must ask for your cooperation and understanding in not only supplying us with correct information, but with our office policies as well. We hope that the following information is helpful in guiding you through your years as a part of Sweetwater Medical Associates. We ask that you keep in mind this letter in no way constitutes a contract between the patient and the physician, but serves as an outline for some of our most important policies that must be followed to keep our office open and available to our patients.

Appointments:

We accept patients by appointment. As a courtesy, appointments are usually confirmed the day before via our automated system. We caution you not to rely on a confirmation from our office to remember your appointment, as you are still responsible for arriving on time or for canceling when you are unable to make your appointment. Failure to arrive or give a 24-hour notice for a cancelled appointment will cause the patient account to incur a charge of $25.00. These fees are subject to change at any time without written notice. We ask that you call to schedule your appointment during regular business hours. Anyone calling after hours may leave this information on the appropriate voice mailbox, the system will guide you through the prompts, and your call will be returned the next business day. Late arrivals may be asked to reschedule. We understand walk-in appointments at times are needed. Therefore….. Walk-in appointments have been added to our practice. There may be a wait, but rest assured we will do our best to provide you with the same quality care.

Physicals go by many different names. They include, but are not limited to, General Physical, Annual Exam, and Preventive Exam; for women, Well Woman Exams; and in some cases for men, Well Man Exams. Commercial carriers usually pay for one exam every 365 or more days, while some pay one per calendar year. Medicare does not cover any type of physical/preventive exam. Medicare will cover, one prostate screening a year, and for women, one collection of a PAP smear and one breast exam every two years unless the patient is high-risk, i.e., history of abnormal PAP smears.

Collection of Pertinent Data

We must collect certain information from patients in order to file their insurance while other information is collected as office policy. This information is protected by the HIPAA regulations and when destroyed, it is done so in a secure manner. Once a year we will ask patients to review their demographic information for updates, which includes, but is not limited to, address, phone number, insurance information, drivers license and social security number. Some of this information gathered is to help ensure your privacy and keep your insurance safe from forgery.

Prescription Refills

You must call your prescription refills to your pharmacy allowing us at least 48-hours for processing.

Hospitalization

When hospitalization becomes necessary, we utilize a hospitalist for the admission and treatment of our patients. Hospitalists are physicians with specific expertise in hospital treatment and evaluation. The hospitalist is an extension of our office and there is 2-way communication between physicians. Follow-up after hospitalization is here in our office.

Forms and Medical Records

Forms are subject to the charges that may change at any time without written notice. The Medical Assistant working with the physician will be able to inform you of the charges associated with this type of request. Medical records being released to certain persons are also subject to charges that vary depending on the number of pages contained in the record. Persons that will be charged for records include but are not limited to: the patient, attorneys and insurance companies for determination of new coverage. For records please call the main number and follow the prompts.

Insurance

While we will make every effort to verify a patient's insurance coverage, the patient needs to understand that verification is never a guarantee of payment. It is the responsibility of the patient to know their policy, what it covers and when they may be responsible for non-covered services. Should the insurance company fail to make payment for any number of reasons, the amount owed will then be billed to the patient and due payable upon receipt.

We must receive the correct insurance information for that day of service before the physician sees the patient. Changes may and should be called to our verification desk in advance of your appointment. This will help avoid any delay or problems with verification, which in turn could delay your appointment time. We are unable to accept insurance applications as proof of insurance. Claims will be filed to one insurance company only and will include submission to a secondary if applicable. If the patient fails to supply the correct information before seeing the physician then the patient will be responsible for payment at that time and there will be no allowance for insurance adjustments. For these patients and self-pay patients no itemized receipt will be issued until services are paid in full. Upon receipt of insurance cards, it is our policy to copy the card and stamp it with the date received. This allows us to know when we were presented with the information. We are unable to retroactively file any insurance claim.

Billing and Collections

Once a payment is determined to be the responsibility of the patient, you will receive your 1st billing, which is due upon receipt. Should you be unable make payment at that time we ask that you call our business office at 281/494-4900 x220 in order for us to document the situation and to discuss when payment should be expected. If there is no contact with or payment made to our office a 2nd notice will be issued, then if necessary a third and final notice. If the final notice goes unheeded then the account will be turned over to our collections agency and due process will begin.

Once again we want to thank you for allowing us to take care of your medical needs and look forward to a long and fruitful relationship. We appreciate your understanding and cooperation of our policies and procedures that are in place to help keep our office running smoothly and efficiently for you, our patient.

Sincerely,

The Physicians and Staff at Sweetwater Medical Associates

Please note: We reserve the right to refuse service to any person that may choose not to follow our office policies and procedures.

Sweetwater Medical Associates, PLLC
16651 Southwest Freeway, #100
Sugar Land, Texas 77479
281/494-4900

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the care of the patient named on this form, including, but not restricted to drugs, medications, lab tests or other studies, which may be used, by the physician and/or his/her qualified designate.

I understand and acknowledge that I am solely responsible for providing the valid and correct insurance information for any services provided by Sweetwater Medical Associates before services are rendered. I also understand by failing to supply said information that I will be entirely responsible for payment in full.

Sweetwater Medical Associates, PLLC verifies insurance coverage & files claims as a courtesy to our patients'. Upon verification of patient benefits, every insurance company has a disclosure statement stating there is no guarantee of coverage. Therefore, we too cannot guarantee your coverage. It is your responsibility, as the insured, to confirm with your insurance company as to what is covered and what is not covered, under your policy. By signing below, I acknowledge that any charges, not covered under my insurance, are my sole responsibility.

At the time services are rendered I acknowledge and understand: 1) I am fully responsible for cash payment (if self pay or auto accident), co-payment, deductible and/or co-insurance of such services and agree to pay my bill ***at the time services are rendered unless other arrangements are made with the financial department in advance***. 2) That it is my sole responsibility to provide the correct insurance information for the services rendered on any given day in order for Sweetwater Medical Associates to bill my insurance company. 3) Sweetwater Medical Associates will not bill to any insurance provided after services are rendered. 4) Should I fail to provide the correct information at the time services are rendered, I am ultimately responsible for payment in full, before being issued an itemized receipt, and that no contractual adjustments will be honored.

I authorize Sweetwater Medical Associates to release information as required to my insurance or third party payer (including my employer or my employer's worker's compensation carrier) for the purposes of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental issues. I also authorize Sweetwater Medical Associates to bill my insurance or third party payer and receive payment directly from them for services rendered.

This authorization shall remain valid for a period of one year or until such as I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Patient Name: _____ Signed: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____/_____/_____

HIPAA Notice of Privacy Practices

Sweetwater Medical Associates, PLLC
16651 Southwest Freeway, Suite 100
Sugar Land, Texas 77479
281/494-4900

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and licensing. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information. Requests for the following must be made on forms supplied in our office and charges may apply depending on the request

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. The copying of medical records is subject to charges allowed and governed by state law.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Should you request restriction for payment purposes, you will then be responsible for payment in full at time services are rendered.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will post any changes of this notice in the reception area. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please call our HIPAA Compliance line at 281/494-4900 X205 and follow the instructions.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Sweetwater Medical Associates, P.L.L.C.
16651 Southwest Frwy., Suite 100
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Jeffery T. Alford, M.D. ~ Jonathon B. Shaffer, M.D. ~ Dina B. White, M.D.

HEALTH INFORMATION DISCLOSURE

In a continuing effort to enforce privacy regarding our patients' medical information, we are requesting that you provide a designated telephone number where messages can be left. Our preference is always to speak with you, but we do understand you will not always be available to be contacted. Please list all telephone numbers where we can leave a message and you are able to retrieve it.

Phone #1 _____

Phone #2 _____

Instruction/Comments _____

Patient Signature: _____ Date: _____

PATIENT RESPONSIBILITY

Thank you for allowing Sweetwater Medical Associates to be a part of your medical care, we greatly appreciate being your physicians.

I understand that when my physician has ordered any lab work or radiological procedures it is my first responsibility to follow through and have the ordered test performed. I understand that if I have not received a call or letter from this office, or I am unable to retrieve my results from the automated phone system, it is also my responsibility to call the office for my results about four weeks after the tests are performed.

Secondary to the nature of managed care and their mandate to have your lab test and radiological test sent to different location; it is imperative that we have a constant communication with you in order to review results.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Sweetwater Medical Associates
History Questionnaire

Name: _____ **DOB:** _____/_____/_____ **Date:** _____/_____/_____

CURRENT MEDICATIONS: LIST ALL MEDICATIONS YOU ARE TAKING, BOTH PRESCRIPTION AND NON-PRESCRIPTION. INDICATE STRENGTH AND NUMBER OF PILLS A DAY.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

LIST ANY ALLERGIES TO MEDICATIONS: INCLUDE THE EFFECTS THE MEDICATIONS MAY HAVE.

_____

PAST MEDICAL HISTORY: LIST ANY CHRONIC MEDICAL PROBLEMS YOU MAY HAVE, i.e. ALLERGIES, ASTHMA, DIABETES, HIGH BLODD PRESSURE, HEART ATTACK, LIVER OR KIDNEY PROBLEMS, etc....

_____

_____

_____

PAST SURGICAL HISTORY: LIST ALL PRIOR SURGERIES AND YOUR AGE WHEN THEY OCCURRED.

_____

_____

WHEN WAS YOUR LST COLONOSCOPY? _____ BONE DENSITY SCAN? _____
WHEN WAS YOUR LAST PAP SMEAR? _____ WHEN WAS YOUR LAST MAMMOGRAM? _____
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? ○YES ○NO MAMMOGRAM? ○YES ○NO
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ○YES ○NO

IMMUNIZATIONS: WHEN WAS YOUR LAST TETNUS SHOT? _____ PNEUMONIA SHOT? _____

SOCIAL HISTORY:
DO YOU SMOKE? ○YES ○NO HOW MANY PACKS PER DAY? _____ WHEN DID YOU START? _____
PAST HISTORY OF SMOKING: WHEN DID YOU START? _____ WHEN DID YOU QUIT? _____
DO YOU DRINK ALCOHOL? ○YES ○NO WHAT TYPE? _____ NUMBER PER DAY? _____
DO YOU USE ILLEGAL DRUGS? ○YES ○NO WHAT TYPE? _____
HAVE YOU EVER USED A NEEDLE TO ADMINISTER ANY ILLEGAL DRUG? ○YES ○NO
DO YOU HAVE A TATOO? ○YES ○NO
WHAT IS YOUR OCCUPATION? _____
DO YOU EXERCISE? ○YES ○NO HOW OFTEN? _____ HOW LONG? _____
DO YOU WEAR YOUR SEAT BELTS? ○YES ○NO

FAMILY HISTORY: DO ANY FAMILY MEMBERS HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

HIGH BLOOD PRESSURE	FAMILY MEMBER: _____
CANCER (INCLUDE TYPE)	FAMILY MEMBER: _____
DIABETES	FAMILY MEMBER: _____
HEART ATTACK/DISEASE	FAMILY MEMBER: _____
STROKE	FAMILY MEMBER: _____
ASTHMA/ALLERGIES	FAMILY MEMBER: _____
OTHER	FAMILY MEMBER: _____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:

_____
Name of person or organization

_____
Name of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of person or organization

_____
Name of person or organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Sweetwater Medical Associates, PLLC. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
The person or organization to which it is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Name of patient (Print or type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

Lab Results

Effective May 1, 2012:

All Lab results will now be available through our patient portal. We will no longer make general calls regarding your lab results.

In order to receive labs, you must provide our office with a valid email address. This is required in order to help us Web enable you so you will be able to access the patient portal through eClinical Works. This is a secured site that you will log into and obtain your results. You will be notified via email, by eClinical Works, of your username and password that will be required for you to log into our secured patient portal. Once you have successfully logged in, you will be able to choose your own user name and password. Thereafter, once your lab results are available, you will receive an email notification and will be able to log into the portal and see those results.
Please speak to the Receptionist or Medical Assistant if you have not yet registered.

____ I understand that I must register to have access to the patient portal in order to receive my lab results.
My email address is: _____

____ I DO NOT have access to the internet or email and will not be able to access the patient portal. I request that I receive my lab results via:

____ Phone: _____

OR ____ Mail to: _____

_____

Patient Name: _____

Signed: _____ Date: _____

PATIENT SYMPTOMS UPDATE

SWEETWATER MEDICAL ASSOCIATES

Providers: Jeffory Alford, M.D. Dina White, M.D. Jonathon Shaffer, M.D.

Patient Name: _____ Today's Date: _____ DOB: _____ AGE: _____

Best Daytime #: _____ Best Evening #: _____ e-mail: _____

Height: _____ Weight: _____ ( ) OK to leave message? Y / N

General Health Questions: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
High Blood Pressure, Low Blood Pressure, Rapid Heart Rate, Irregular Heart Rate, etc	Y / N
High Cholesterol	Y / N
Difficult Breathing (COPD, Asthma, etc)	Y / N
Digestive Disturbances (Indigestion, Constipation, Irritable Bowel Syndrome, etc)	Y / N
Endrocrine (Diabetes, Thyroid, etc)	Y / N
Chronic Pain Syndromes (Chronic Fatigue Syndrome, Fibromyalgia, etc)	Y / N
Migraines or Other Headaches	Y / N

Neurological & Brain Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you have a history of Epilepsy or Seizure activity?	Y / N
Have you ever had abnormal involuntary muscle contractions, jerking or convulsions?	Y / N
Have you ever had a mini stroke? If yes, did you lose consciousness?	Y / N
Have you ever had a concussion? If yes, did you lose consciousness?	Y / N
Have you ever Fainted or had any unexplained loss of consciousness? Explain	Y / N
Have you ever had unexplained episodes of Confusion or Loss of Awareness?	Y / N
Do you ever feel Disoriented, Feel Brain Fog, Zone Out, lose track of time or where you are?	Y / N

Quality of Sleep: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you stop breathing, choke, or gasp for air during sleep?	Y / N
Do your legs kick at night and interfere with your sleep?	Y / N
Have you been told that you snore loudly?	Y / N
Do you have difficulty falling and staying asleep?	Y / N
How many hours of restful sleep do you get most nights?	_____

How likely are you to Doze off or Fall Asleep in the following situations? (0=Never, 1=Slight, 2=Moderate, 3=High)

Sitting and Reading	0 1 2 3	Lying Down to Rest in the Afternoon	0 1 2 3
Watching Television	0 1 2 3	While Having a Relaxed Conversation	0 1 2 3
Sitting Quietly After Lunch	0 1 2 3	In a Car While Stopped at a Traffic Signal	0 1 2 3
As a Passenger in a Car for One Hour	0 1 2 3	Sitting Inactive in a Seminar, Theater or Meeting	0 1 2 3

Bladder Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you lose urine while coughing, sneezing, laughing, lifting, jumping or running?	Y / N
Do you use protective undergarments because you cannot hold your urine?	Y / N
Do you wet your clothing because you cannot make it to the bathroom in time?	Y / N
Do you have to hurry to empty your bladder when full?	Y / N
How often do you; urinate during the day? _____ times; wake to urinate during the night? _____ times	

Balance & Fall Prevention: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have you ever Fainted, Lost Your Balance, Feel Dizzy or Unsteady?	Y / N
Does dizziness or imbalance problems interfere with your job or your household responsibilities?	Y / N
Do you feel dizzy when rising from a seated or lying position?	Y / N
Have you fallen more than once in the past year?	Y / N

Nerve and Muscle Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you experience ANY of the following (*please check those that apply*):	
( )Radiating Pain, ( )Numbness, ( )Tingling, ( )Burning, ( )Coldness, ( )Sharp Pain, ( )Dull Pain	
In The: ( ) Neck, ( ) Shoulders, ( ) Arms or ( ) Hands (ie Upper extremities)	Y / N
In The: ( ) Low Back, ( ) Hips or ( ) Legs (ie Lower Extremities)	Y / N
Have you experienced loss of motion or weakness in your neck, shoulders, arms or hands?	Y / N
Have you experienced loss of motion or weakness in your low back, hips or legs?	Y / N
Have you been told that you have Neuritis or Neuropathy?	Y / N
Do you experience tremors, spasms, cramps, involuntary muscle movements?	Y / N

Cognitive Brain Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have daily problems with making judgments or decisions?	Y / N
Have daily problems with memory / Repeat the same things over and over again (questions, stories, statements) ?	Y / N
Have you been told that you may have dementia or pre-dementia?	Y / N
Have feelings of Anxiety and/or Depression?	Y / N
Have trouble handling financial affairs (paying bills) or learning how to use a tool, appliance or gadgets?	Y / N

Cognitive Behavioral Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have difficulty getting organized or Avoid getting started on a challenging task?	Y / N
Have trouble completing assignments or tasks?	Y / N
Fidget or squirm with your hands or feet when you have to sit for a long time?	Y / N
Feel overly active or feel like you have to constantly do something, like you were driven by a motor?	Y / N

Allergy & Immunology: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you have Allergy and Hay Fever symptoms, such as sneezing, watery nasal drainage and nasal itching?	Y / N
Do you have persistent nasal congestion and/or post nasal drip?	Y / N
Do you have sinus problems, frequent colds, sinus headaches?	Y / N
Do your eyes itch, water, get red and/or swell?	Y / N
Do you have asthma, tight chest, and or persistent cough?	Y / N
Do you have skin problems such as eczema, hives or itching?	Y / N
Are you aware of any Food Allergies that you may have?	Y / N
My Symptoms are Worse when:	
( ) Seasons Change ( ) going from indoors to outdoors ( ) in parks and grassy areas ( ) around animals	
( ) while vacuuming or around dust ( ) in the morning and/or after waking	
Do you take medications to control your allergies? If so, describe: _____	
Do they help?	Y / N

Major Accidents/Traumas: _____

Major Surgeries: _____

Medications: _____

This Patient Symptoms Update, which will be part of your medical record, lists symptoms and other factors that may allow your physician to recommend appropriate diagnostic studies to better manage your care. *Upon review and approval*, you may be contacted by our Medical Services Scheduling Company to schedule these tests.

Patient Signature: _____ Date: _____

(rev 2-9-2017, Fax 281-310-6330)

Please Provide your Primary Pharmacy Information

Patient Name: _____

Pharmacy Name: _____

Pharmacy Phone #: _____

If you do not have the number, please give the address or location of your primary pharmacy:

_____