Sarah Biggs, M.D.
Andrew Sauer, PA-C
1900 South Coulter, Suite D
Amarillo, TX 79106
Phone: 806-359-5461
Fax: 806-356-0045

Registration Form

Today's Date:	Primary Care Physician:	
SS#:	Date of Birth:	Gender: ☐ Male ☐ Female
Last Name:	First Name:	Middle Initial:
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐		
Mailing Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
Would you like to sign up for the patient portal so you can view your lab results? ☐ Yes ☐ No		
Employer:		Employer Phone:
Mailing Address:		
City:	State:	Zip:

Primary Insurance: Policy Holder Information	**Secondary Insurance: Policy Holder Information:**
Policy Holder Name:	Policy Holder Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
Insurance Company:	Insurance Company:
Ins. Co. Address:	Ins. Co. Address:
Group # / Contract #:	Group # / Contract #:
Employee/Cert #: Deductible: $	Employee/Cert #: Deductible: $

FINANCIAL RESPONSIBLE PARTY

Complete this section only if the information is different from the Patient Information Section

Guarantor's Relationship to Patient:	Gender: ☐ Male ☐ Female
Date of Birth:	SS#:
Last Name:	First Name:
Address:	City/State/Zip:
Employer:	Phone:
Address:	City/State/Zip:

PARENT/LEGAL GUARDIAN CONTACT INFORMATION (PATIENTS 18 AND YOUNGER)	EMERGENCY CONTACT INFORMATION (PATIENTS 18 AND OVER)
Parent/Guardian Name:	Emergency Contact Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Parent Home Phone:	Contact Home Phone:
Parent Cell Phone:	Contact Cell Phone:

PREFERRED PHARMACY:
Name of Pharmacy:
Location:
City/State/Zip:
Phone Number:
Fax Number:

DEMOGRAPHICS
We are now required by CMS to collect information on race and ethnicity.
☐ African American ☐ American Indian or Native Alaskan ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native Hawaiian ☐ Decline to State ☐ Other
Do you have any additional needs or requests?

Patient/Guardian Signature: _____ Date: _____

CANCELLATION/NO SHOW POLICY FOR DOCTOR APPOINTMENT

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Out of courtesy, you will receive a reminder call the day before your scheduled appointment. At each appointment, you will also receive an appointment card with detailed information about your next appointment. We also have our answering service that is available to take calls 24 hours a day 7 days a week.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company and must be paid prior to rescheduling.

AFTER THREE NO SHOW APPOINTMENTS, YOU MAY BE DISCHARGED AS A PATIENT.

SCHEDULED APPOINTMENTS

We understand that delays can happen; however, we must try to keep our other patients and doctors on time.

If you arrive 15 minutes past your scheduled appointment time, we will reschedule your appointment.

HEALTH INFORMATION EXCHANGE (HIE)

It is a database where records are electronically stored. Doctors can sign into this database and see records from other doctor's you have seen in the past.

Only doctors you are currently seeing are allowed to access this database. Emergency rooms in Amarillo are set up on the database.

This database is Health Insurance Portability and Accountability Act (HIPPA) approved.

Printed Name: _____ Signature: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Patient Name: _____ Date of Birth: _____

1. Please list the family members and/or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

   _____
   Name Phone Number

   _____
   Name Phone Number

   _____
   Name Phone Number

2. Please list the family members and/or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

   _____
   Name Phone Number

3. Can confidential messages (for example, appointment information) be left on your answering machine?
   ☐ Yes ☐ No

Please note, while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, Relation to Patient: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

Records requested from:

Primary Care Physician/Clinic/Hospital_____

Address: _____

Phone: _____

Fax: _____

to the following person(s):

Sarah Biggs, M.D.
Andrew Sauer, PA-C
Amarillo Medical Specialists
1900 S. Coulter, Suite D
Amarillo, TX 79106
Phone: (806) 359-5461
Fax: (806) 356-0045

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Signature: _____

Sarah Biggs, M.D.
Andrew Sauer, PA-C

Date: _____

Name:_____ DOB:_____

Please answer all questions to the best of your ability. All the information is kept in the strictest confidence and is for your provider's use in accessing your total health care needs. If you have any reservations, please feel free to discuss after reading the questions. PLEASE PRINT YOUR RESPONSES. Thank you.

CHIEF COMPLAINT

_____

HPI

When did this problem(s) start? (mm/dd/yy) _____

Since it began has it: worsened____, bettered____, or stayed the same____. (Please Check One)

Which season are your symptoms worse? _____

What months are your allergy symptoms worse? (Please circle)

JAN – FEB -MAR – APR – MAY – JUNE – JULY – AUG – SEPT – OCT – NOV - DEC

What triggers your allergy symptoms? (Please circle)

Dust – Pollen – Cats – Dogs – Animals – Leaves – Dampness – Temperature Changes – Weather Changes – Cold Air – Exercise – Stress – Alcohol – Smoke – Perfumes – Odors – Viral Colds – Food – Cabins – Vacations

Is there anything that makes your symptoms better?

_____

Have you ever undergone allergy testing in the past? Circle (Yes/No)
If so, where and when have you had allergy testing completed? _____

Have you ever utilized allergy shots? Circle (Yes/No)
If so, who prescribed allergy shots? _____
How long where allergy shots used? _____

MEDICATION ALLERGIES

Please list any medications or products you have taken which may have caused a **true allergic reaction or undesirable side effects** (hives, itching, rash, difficulty breathing, muscle aches, cough, nausea etc)

NAME OF MEDICATION	REACTION	NAME OF MEDICATION	REACTION

PAST MEDICAL HISTORY:

Please review this sheet and mark any condition you have been diagnosed with in the past.

☐ I have reviewed the information on this page, and I have no past medical history to report.

ILLNESS	YES	NO	ILLNESS	YES	NO	ILLNESS	YES	NO
Alcohol/Drug Abuse			Emphysema			Pneumonia		
Anxiety			Gastric Reflux			Psoriasis		
Asthma			Glaucoma			Recurrent Infections		
Auto Immune Disease			Headache			Rheumatoid Arthritis		
Cancer			High Blood Pressure			Shingles		
Chronic Bronchitis			Irritable Bowel			Sinus Infections		
COPD			Kidney Disease			Sleep Disorder		
Coronary Artery Disease			Liver Disease			Sleep Apnea		
Crohn's Disease			Lupus			Neuropathy		
Diabetes			Peripheral Vascular			Thyroid Disfunction		

CURRENT MEDICATIONS

Please list ALL the medications you are currently taking, including over the counter medications, vitamins, and supplements. Please use the back of page if necessary.

MEDICINE	PRESCRIBER	DOSE	FREQUENCY

PAST SURGERIES/SERIOUS ACCIDENTS

Please list all surgeries or serious accidents you have had in the past.

SURGERY	DATE		SURGERY	DATE

PAST HOSPITALIZATIONS

Please list all hospitalizations, reason, and date you have had in the past.

HOSPITALIZATION	REASON	DATE

FAMILY HISTORY

FAMILY	AGE (Or Age At Time Of Death)	HEALTH CONDITION(S) Please list any diseases which tend to run in the family, such as high blood pressure, heart disease, diabetes, cancer, gout, asthma, stomach ulcers, epilepsy, tuberculosis, cystic fibrosis, muscle disease, stroke, or thyroid disease.
FATHER		
MOTHER		
BROTHER		
SISTER		
FAMILY		

SOCIAL HISTORY

If the patient is a child, please name the school or daycare they attend:	
What type of occupation do (or did) you have?	
Current employment status:	
How many children do you have? # Girls # Boys	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow	
Education: ☐ Elementary ☐ High School ☐ College ☐ Graduate School	
Have you ever smoked cigarettes regularly? ☐ Yes ☐ No	Currently smoking? Yes ☐ No ☐
If yes, how many packs per day?	How many years?
Are you thinking about quitting? ☐ Yes ☐ No	Date you quit smoking?
Do you use snuff or chewing tobacco? ☐ Yes ☐ No	If so, how much?
Do you drink alcohol? ☐ Yes ☐ No	If so, what type?
How many drinks in a day?	How many years?
Do you currently use marijuana, cocaine, or other "recreational" drugs? Yes ☐ No ☐	If yes, which ones?
Do you drink caffeinated beverages? ☐ Yes ☐ No	How many daily?
Do you follow a special diet? ☐ Yes ☐ No	Type:

ENVIRONMENTAL HISTORY

Please check all that apply and fill in the blank as requested.

Home:	Apartment		Mobile Home		House		Other	
Home Location:	City		Suburb		Farm		Country	
Age of Home:								
Heating:	Forced Air		Boiler		Space Heater		Wood	
Air Conditioning:	Central		Window		Swamp Cooler		None	
Humidifier:	Yes				No			
Bedroom Floor:	Wood		Carpet		Linoleum		Other	
Bedroom Location:	First Floor		Second Floor		Basement			
Basement:	Damp		Dry		Flood in the Past		Visible Mold	
Have Mold Issues Been Found at Home, School, or Work?								

ANIMALS AND PETS

Please list all pets and any animals you may have been in contact with within the last year.

Animal	Years Owned	Indoor	Outdoor

FAMILY HISTORY OF ALLERGIES

Please check all that apply and fill in the blank as requested.

Condition	Father	Mother	Sibling	Child
Asthma				
Allergy				
Eczema				
Food Allergy				
Infections				
Thyroid				
Other				

MEDICATIONS THAT MAY INTERFERE WITH SKIN TESTING

- Due to continued advances, not all medications may be listed at time of printing.

PLEASE CHECK ALL THAT CURRENTLY APPLY TO YOU					
EYE SYMPTOMS		**EARS**		**NASAL/THROAT SYMPTOMS**	
Itching		Ear infections		Stuffy nose	
Watering		Itchy		Runny nose	
Swelling		Popping/Cracking		Sneezing	
Red		Hearing loss		Itchy nose	
Painful		Earache		Drainage Down Throat	
Vision Change				Facial Pressure	
				Sore Throat	
				Headaches	
				Snoring	
				Loss of Sense of Smell	
CHEST		**ABDOMINAL / GI**		**SKIN SYMPTOMS**	
Chest tight or heavy		Suspected food reaction		Eczema	
Wheezing		Vomiting		Hives	
Coughing		Acid Reflux		Itching	
Phlegm		Heartburn/Indigestion		Other	
Symptoms at night		Abdominal Pain		**OTHER**	
Symptoms with exercise		Diarrhea		Bee sting reaction	
				Latex reaction	
	Q			Drug reactions	
				Metal reactions	

Please list any additional conditions not shown above:

•

• Due to continued advances, not all medications may be listed at time of printing.

• For your safety and accurate results, at each visit, please list all your current medications **(including non-prescription and those prescribed elsewhere).**

• It is important to let us know if you are pregnant or could be pregnant.

STOP THESE MEDICATIONS FIVE DAYS BEFORE SKIN TESTING:

ORAL ANTIHISTAMINES:
- Allegra (Fexofenadine)
- Benadryl (Diphenhydramine)
- Claritin, Alavert (Loratadine)
- Clarinex (Desloratadine)
- Xyzal (Levocetirizine)
- Zyrtec (Cetirizine)
- All over-the-counter medications for allergy, cough, cold, sleep, or nausea that include:
  - Acrivastine (ex. Semprex)
  - Azatadine (ex. Optimine, Trinalin)
  - Brompheniramine (ex. Dimetapp)
  - Carbinoxamine (ex. Palgic, Arbinoxa)
  - Chlorpheniramine (ex. Actifed, Aller-chlor, Chlor-Trimeton, Tylenol Allergy)
  - Dimenhydrinate (ex. Dramamine)
  - Diphenhydramine (ex. Unisom, Sominex, Triaminic, many with "PM" in the title)
  - Doxylamine (ex. Nyquil, Unisom)
  - Hydroxyzine (ex. Atarax, Vistaril)
  - Meclizine (ex. Antivert)
  - Pheniramine
  - Promethazine (ex. Phenergan)
  - Tripolidine (ex. Actifed)
  - Phenylephrine or Pseudoephedrine (Sudafed)

ANTIHISTAMINE NOSE SPRAYS:
- Astelin, Astepro, Dymista (Azelastine)
- Patanase (Olopatadine)

ANTIHISTAMINE EYE DROPS:
- Alaway, Claritin, Zaditor, Zyrtec (Ketotifen)
- Bepreve (Bepotastine)
- Elestat (Epinastine)
- Emadine (Emedastine)
- Lastacaft (Alcaftadine)
- Livostin (Levocabastine)
- Naphcon-A, Opcon-A, Visine-A (Pheniramine)
- Optivar (Azelastine)
- Pataday, Patanol (Olopatadine)

HEARTBURN MEDICATIONS (H2 BLOCKERS):
- Axid (Nizatidine)
- Pepcid, Tums Dual Action (Famotidine)
- Tagament (Cimetidine)
- Zantac (Ranitidine)

ALL HERBAL SUPPLEMENTS: (including Astragalus, Feverfew, Green Tea, Licorice, Milk Thistle, Saw Palmetto, St. John's Wort)

• Discuss alternative management for your symptoms with your Allergist.

• Do **NOT** stop the following: **asthma medications** (including inhaled corticosteroids, short or long-acting beta agonists, and Singulair), **antibiotics, certain heartburn medications** (Prilosec, Nexium, Prevacid, Zegerid, Aciphex, Dexilant, and Protonix), and **certain nasal sprays** (Atrovent, Flonase, Nasacort, NasalCrom, Nasonex, Rhinocort, Omnaris, Qnasl, Veramyst, and Zetonna).

Some antidepressants/sedatives MAY interfere with skin testing and should be brought to the attention of your Allergist.
NOTE: Do NOT stop these medications prior to discussion with your Allergist AND the Prescribing Physician.

Tricyclic Antidepressants (TCAs):	**Benzodiazepines:**	**Atypical antidepressants/Sedatives:**
Elavil, Limbitrol (Amitripyline), Doxepin, Tofranil (Imipramine), Vivactil (Protriptyline), Surmontil (Trimipramine), Norpramin (Desipramine), Aventyl, Pamelor (Nortriptyline).	Klonopin (Clonazepam), Valium (Diazepam), Ativan (Lorazepam), Versed (Midazolam), Restoril (Temazepam), Estazolam, Xanax (Alprazolam), Ativan (Lorazepam).	Remeron (Mirtazapine), Quetiapine, Wellbutrin (Bupropion), Eszopiclone, Oleptro (Trazodone), Ambien (Zolpidem).

• **Certain antidepressant medications** do **NOT** interfere with allergy testing: **SSRIs** (Celexa (Citalopram), Lexapro (Escitalopram), Prozac, Sarafem (Fluoxetine), Paxil, Pexeva (Paroxetine), Zoloft (Sertaline)) and **SNRIs** (Effexor (Venlafaxine) , Pristiq (Desvenlafaxine), Cymbalta (Duloxetine)).

• **Steroid Medications** may also need to be discontinued. Please call the allergy clinic so we may decide if the medications need to be discontinued and for how long. In some cases, continued steroid use may be appropriate.

IF YOU ARE NOT SURE ABOUT A MEDICATION, PLEASE CALL BEFORE YOU TAKE IT.

GENERAL CONSENT FOR TREATMENT

Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for any recommended surgical, medical or diagnostic procedure to be utilized. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. This consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions, discontinue, or decline services. You have the right to discuss the treatment plan with your medical provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, it is encouraged you ask questions.

I voluntarily request Amarillo Medical Specialists, its physicians, or other designees as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the condition which has brought me to seek care at this practice or any other condition that has been identified through the before mentioned methods.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship Date

FINANCIAL RESPONSIBILITY AND ASSINGMENT OF BENEFITS

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of services unless other arrangements have been made in advance with our office manager or Amarillo Medical Services. Necessary forms will be completed to help expedite insurance carrier payments. **However, the patient or guarantor is responsible for all fees regardless of insurance coverage. It is the responsibility of the patient or guarantor to inform us of any insurance changes and to renew any referrals necessary from patient's PCP. It is the patient or guarantor's responsibility to understand the benefits or lack thereof for the patient's particular insurance plan.** The patient or guarantor is responsible for knowing which laboratory or imaging facility is contracted with their insurance. If use of a specific lab or x-ray facility is required by the patient's insurance, it is the responsibility of the patient or guarantor to notify the clinic staff before the service is rendered. Any patients without insurance coverage must provide payment at time services are rendered.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Amarillo Medical Specialists, LLP for any and all medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Amarillo Medical Specialists, LLP to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, and to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime claims. This order will remain in effect until revoked by me in writing.
I have requested medical services from Amarillo Medical Specialists, LLP on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment regardless of coverage. I further understand that fees are due and payable on the date that services are rendered and agree to pay any charges not covered by insurance in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

_____ _____
Patient/Responsible Party DATE

_____ _____
AMS Representative Signature DATE