Janet Kershaw-McLennan, M.D.

8105 Morro Road, Suite D, Atascadero, CA 93422 805-466-7722
Allergy/Immunology

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.

PATIENT INFORMATION (Please Print)

Date__________ Home Phone ______________ Cell Phone______________ Primary: ☐ Home ☐ Cell

Name____ Soc. Sec.#________________
Last Name First Name Initial

Address____

City____________________ State______ Zip__________ Age______ Birth date____________

Gender: ☐M ☐F ☐Additional category____________ Preferred Prounouns ______________

Patient Employed by______________________________ Work Phone________________

Referral Source:__________________________ Primary Physician:________________

In case of an emergency, who should be notified?______________________ Phone____________

May we leave results on your cell? ☐Y ☐N OR home? ☐Y ☐N Email:____________________

Please indicate your preferred method of communication for confirmation of appointments: ☐ Phone ☐ Text ☐ Email

Is there anyone you would authorize to receive medical information other than yourself? Please print name(s) and relationship: ____

PRIMARY INSURANCE

Insurance______________________________________ Subscriber #________________

Subscriber name________________________________ Group #____________________

Relation to patient______________________________ Birthdate___________________

ADDITIONAL INSURANCE

Insurance______________________________________ Subscriber #________________

Subscriber name________________________________ Group #____________________

Relation to patient______________________________ Birthdate___________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance(s) and assign directly to Dr. Janet Kershaw-McLennan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. ***If you need to cancel your appointment, please notify our office 24 hours in advance or there will be a $100 charge applied.***

______________________________ ____________________ ____________
Patient Signature Relationship to Patient Date

Janet Kershaw-McLennan, M.D.

NOTICE OF PRIVACY PRACTICES

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so, by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:
1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. Authorization to Mail, Call, Text or Email: I certify that I understand the privacy risks of mail, phone calls, text and email. I hereby authorize Dr. Janet Kershaw-McLennan, M.D. or a representative to mail, call, text or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dr. Janet Kershaw-McLennan, M.D. to that effect in writing.
3. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Janet Kershaw-McLennan. There is a charge for copying records.
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Janet Kershaw-McLennan. You must provide us with a reason that supports your request for amendment.
6. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact Dr. Janet Kershaw-McLennan.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Janet Kershaw-McLennan. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Janet Kershaw-McLennan.

I hereby acknowledge that I have been presented with a copy of Dr. Janet Kershaw-McLennan's Notice of Privacy Practice.

By: ______________________________ ______________________________ ______________

Patient or Patient Representative's Signature | Print Patient's Name | Date

Dr. Kershaw- McLennan

Allergy – Asthma- Immunology

Patients Name: ______________________

Date Of Birth: ______________________

PATIENT QUESTIONNAIRE

Why have you sought care with us today? ____

____

Who is your regular family doctor? ______________________ Specialists?______________________

Symptoms: Please circle all the symptoms that you have. Fill in the blank for additional symptoms not listed.

Eyes:	Nose:	Mouth/Throat:	Ears:
Itchy	Runny	Pain	Infections
Watery	Congested	Infections	Popping/ Blocked
Infections	Snoring	Post Nasal Drip	Pain
Swelling	Changed/decreased smell	Hoarseness	Ringing
__________	__________	__________	__________
Gastrointestinal:	**Skin:**	**Lungs:**	**Other:**
Pain	Eczema	Shortness of breath	Headaches
Bloating	Hives	Wheezing	Get sick easily
Heartburn	Rash	Cough	Fever
Diarrhea	Itchy	Infections	Fatigue
__________	__________	__________	__________

Triggers: What makes your symptoms occur/worsen? circle all that apply.

Cats Dog Flowers / grass / trees feathers exercise dust smoke mold strong odors

Other (list): ____

What time of the year do you have symptoms? All the time Spring Fall Other: ______________

Previous Allergic Workup, Skin Tests &/or Shots ______________________________

Diet: I eat everything, no restrictions Vegetarian Vegan Other(list):______________

Are you allergic to any foods? No Yes, (list)______________________________

____

Symptoms to those foods? (Circle all that occur)

Swelling/ Angioedema Hives Vomiting Diarrhea Bloating Rash Itchy mouth other:________

Any other foods you do not eat or try to avoid? ______________________________

Other allergies: (circle all that apply)

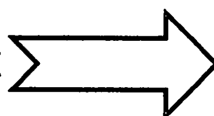
Latex Jewelry/Metals Bee stings Wasp/ Hornet Stings Tape/ Band-Aids Sensitive skin

Other: ____

Are you allergic to any medications? No Yes, (list)______________________________

____

PLEASE CONTINUE ON THE BACK



Current Medications: Please list all over the counter and prescription medications:

Name:	Dose:	Purpose:

Please circle any health issues that you have ever experienced:

General Health: Asthma Eczema Hypertension Hypothyroid Autoimmune Psoriasis

Depression Apnea/ CPAP use Cardiac Diabetes Cancer Other:____________________

☐ None of the Above, I am overall healthy Surgeries/Hospitalizations: ____________________

Smoking/ Vaping: No History Previous Current ______ packs per day x _____ years

Any smokers in household? No / Yes Who? __________ How much? _________ Where? __________

Immunization status: Please circle all vaccines you have received.

S. Pneumonia 23 S. Pneumonia 13 DTaP COVID Flu Shingles Childhood Vaccines

Environmental History: Home: House Apartment Mobile Flooring: Carpet Tile Hardwood

How long have you lived on the Central Coast? ____________ Where did you live before? _______________

Mattress: Age_______ Bedding/ pillows with Down/ Feathers? NO YES

Pets/ Animals: ____Cat ___Dog Chickens Horse other: ____________________

Social History: Occupation or Grade in School: ____________________________

Family history: Please complete for any family members that have the following problems:

Hay fever/ Allergies:	Asthma:	Eczema:	Food Allergies:	Autoimmune:
Other:				

NAME and LOCATION of your preferred pharmacy: ______________________________

Who Completed this form? Patient Parent ________________ Other ______________________

SIGN: ____ Date:__________________