

ALLERGY, ASTHMA, & IMMUNOLOGY MEDICAL GROUP

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Welcome to our office !!

INSTRUCTIONS FOR FILLING OUT THIS PACKET:

- This document contains the following items:
 1. Registration Form = 1 page
 2. New Patient Questionnaire (your medical history) = 4 pages
 3. Insurance Policy = 1 page
 4. HIPAA privacy policy and acknowledgement = 2 pages
- Please fill out all the mentioned forms.
- It will take **approximately 30 minutes** to fill out these forms. By completing them at home, you will save time at the appointment.
- In the questionnaire, not all the questions will be related to your medical condition. If it is not applicable for you, disregard it and move to the next question.
- If you are not sure about a question, skip it. The doctor will go through these questions and any relevant medical history with you at your first appointment.
- After you have completed the forms, be sure to **bring them with you to your first appointment.**

CHECKLIST OF THINGS TO BRING TO YOUR APPOINTMENT:

- Insurance Card (Bring the **actual** insurance card – no pictures or copies)
- Government issued photo ID / Driver's License (the **actual** ID)
- Registration Form
- New Patient Questionnaire
- Insurance Policy
- HIPAA Privacy Acknowledgement
- Co-pays
- Any prior authorization paperwork you may have
- Physician referral forms (if necessary)
- List of prescriptions, herbs, vitamins, over-the-counter medications
- Recent Allergy tests, X-rays, CAT scans, PFTs (if available)

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****PATIENT'S NAME** _____ NickName _____ DATE _____

**Birth date _____ Age _____ Sex _____ Social Security No. _____

**Home Address _____ City/Zip _____

Work Address _____ City/Zip _____

**Phone: Home _____ Work _____ Cell Phone _____

****INSURANCE COMPANY NAME & EFFECTIVE DATE** _____

****POLICY #** _____ ****INSURANCE GROUP #** _____

**Name of Person Carrying Insurance _____ Cell Phone: _____

Relationship to Patient _____ Driver's License No. _____

**Date of Birth of Insurance Policy Holder _____

**Social Security # of Policy Holder _____

**Address of Policy Holder _____

Name and relationship of persons who are allowed to receive personal health information:

Neighbor or Friend _____ Phone _____
Address _____

****Family Physician** _____ Phone _____ Fax _____

Referred By _____ Phone _____

****Pharmacy** _____ Phone _____ Fax _____

****In case of Emergency Contact:** _____ Phone _____

INSURANCE FOR MEDICAL CARE

Patients and responsible parties must ensure that they meet eligibility requirements before the services are rendered. Patients who carry indemnity insurance should know that all services furnished are charged directly to the patient, and that he or she is personally responsible for payments, although we do bill their insurance company for them. All patients and responsible parties including those with HMO insurance are accountable for their co-pays and deductibles at the time of service.

We cannot render services on the assumption that our charges will be paid by an insurance company.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of insurance benefits to Allergy, Asthma, and Immunology Medical Group, INC.

"This Medical Corporation reserves the right, at all times, to designate the licensed physician who will perform any medical services requested of it, irrespective of whether or not the licensed physician so designated is an employee of this corporation."

I have read the above and agree to the above,

Patients' or Responsible Party's Signature

Date

I give permission to Allergy, Asthma, and Immunology Medical Group, INC. to examine and /or treat my child in my absences.

Parents' or Responsible Party's Signature

Date

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ALLERGY QUESTIONNAIRE

Date _____

Patient's Name _____ Birth Date _____ Age _____ Sex _____

Address _____ City _____ Phone _____

Occupation _____ Phone @ Work _____ Ext. _____ Cell Phone _____

Primary Care Physician _____ Pharmacy _____

Referring Physician _____ Phone/Fax _____

Patient's Race: Asian ___ Caucasian ___ African American ___ Pacific Islander ___ Alaskan ___ American Indian ___ Other ___
Ethnicity Hispanic or Latino: Yes ___ No ___ ***Federal Govt. requirement.

List Main Complaint(s):

1. _____ Since When _____

2. _____ Since When _____

3. _____ Since When _____

List All Present Medicines:

Name of the Drug	Dose	Any Relief	Any Side Effects	Taking Since

PRESENT ALLERGY HISTORY:

Review of Systems (Circle the present symptoms: Fill the blanks)

NOSE & SINUSES: Itchy Nose Sneezing Running Nose Suffiness Mouth Breathing Nasal Discharge ___ Clear ___ Yellow/Green

Snoring Sinus Congestion Sinus Pressure Sinus Headaches Nasal Polyps Deviated Nasal Septum Frequent Sinus Infection: ___ per yr

What aggravates attacks: At night Early AM Indoors Outdoors Heat Cold Air East Winds Fog Smog

Change in the weather Dampness/Rain Dust Smoke Cut Grass Garden Work Odors (Paint, Perfume, etc.)

Sprays (Cleaners, Hair, etc.) Exposure to animals - Cats / Dogs / Horses / Birds / Other _____

Worst Seasons (Spring , Summer , Fall , Winter , Year Around). Any other triggers: _____

What medicines relieve the symptoms: _____ (Dose & Since when) _____

Have you had any Surgery of the Nose or Sinuses? _____ (What & When) _____

THROAT:

Itchy Throat Throat Clearing Itchy Palate Post Nasal Drainage Mucus: Clear / Colored Hoarseness Tonsillitis
Choking Sensation / Difficulty Swallowing Frequent Sore Throats -with fever / without fever
Frequent Colds - with fever / without fever How frequent _____(times a year)
Tonsillectomy &/or Adenoidectomy: Yes___ No___ When _____

EARS:

Earache Plugged Ears Popping of the ear Itchy Ears Hearing Loss (Rt)___ (Lt.)___
Discharge from ears PETubes - When _____ Repeated Ear Infections How Many a year _____

EYES:

Itchy Redness Watery Swelling Pus Drainage Eye Glue Shut Stye Blepharitis
What aggravates it _____
What relieves it : Medicine _____ Dose _____

CHEST:

Cough : Dry / Productive Sputum : Clear / Yellow - Green Night Cough Chronic Bronchitis
Wheezing Chest Congestion Shortness of Breath Chest Tightness Night time wheezing
Exercise-induced Wheezing or Cough At what age did your asthma / cough start? _____
How often do you need your Inhaler for acute wheezing or difficulty breathing in a week: _____
Number of Emergency treatments for Asthma in the last year : ___ Last one: _____
How often hospitalized for Asthma in last year : _____ Last one : _____
How many days of school or work missed in the last year : _____
What aggravates attack : At Night Early AM Cold Air Rain East Winds Smog Change in the weather
Dust Cut Grass Pulling Weeds Pets - Cats / Dogs / Others Smoke Strong odors (Perfumes / Cleaners etc..)
Strong Sprays (Aerosol / Hair / Deodorant etc..) Chemicals / Fumes Respiratory Infections Exercise Emotions Medicines
Spring/Summer/Fall/Winter / Year around **Life style changed because of Asthma** (eg. Not play sports or exercise or dance etc....) _Yes No
Have you had Pneumonia _____ When _____

SKIN:

Eczema: Since when _____ Sites involved: Neck / Arms / Back of Knees / Other: _____ ; Triggers: _____
Rash or Hives or Swelling: Since When _____ How often? _____ Triggers: _____
Location on Body? _____ Medications used: _____
Contact Allergy: Rash with Jewelry / Cosmetics / Soaps / Poison Ivy / Poison Oak / Latex (rubber) **Itchy skin** __All over ___ Certain parts
Other: Frequent Boils Skin infections Psoriasis Seborrhea Thrush

INTESTINAL:

Abdominal Pain/Cramps Gas Nausea Vomiting Constipation Diarrhea Blood in Stools Milk Intolerance
Heartburn/Reflux Foods that cause Heartburn/ Reflux _____ Meds used _____

URINARY:

Bedwetting Burning during urination Difficulty Urinating Blood in Urine
Menarche _____(age) Menses - regular/ irregular/ none

GENERAL SYMPTOMS:

Do Allergies affect your life style: Disturbed sleep ___ Tired all the time ___ Cranky quite often ___ Affects work or school ___

Emotional Problems [] Yes [] No; Unable to do certain activities?(eg. Sports, dancing, lawn mowing, dusting etc...) [] Yes [] No

***** **FOOD INTOLERANCE** *****

***** **DRUG INTOLERANCE** *****

****Which FOOD****Reaction Felt *****When it First Occurred** ****Which DRUG****Reaction Felt*****When it First Occurred**

1	*1
2	*2
3	*3
4	*4

BEEES/ WASP/ YELLOW JACKEE/ HORNET STINGS: Never Stung Stung - Once/ Frequently Stinger left behind/ No stinger

What Stung You _____ Date of First & Last Sting _____

Describe Reaction to sting: Local Reaction _____ Anaphylactic Reaction _____ Treatment received _____

IMMUNIZATION HISTORY: Have you had Flu Shot [] Yes? When _____ [] No. Have you had Pneumonia Vaccine [] Yes When _____ [] No

PAST ALLERGY WORKUP: (Circle Pertinent Answers; Fill in Blanks)

NEVER TESTED ___ Tested (When & Where) _____ Physician's Name _____

Results of Allergy Skin Tests: _____

Environmental Control: Never Done/ Dust Control in Bedroom/ Removed the Pets/ Use Air Purifier **Since When** _____

Elimination Diet(s): Never Done/ Food(s) Eliminated _____ How Long _____ Any Improvements _____

Allergy Injections: Never Had/ Had Injections _____ (Yr.) For How Long _____ Any Relief? _____

Physician who gave allergy injections _____

PAST HISTORY OF OTHER ILLNESS: (Circle any / all that apply)

Milk/Formula Intolerance Infantile Colic Eczema Seborrhea Diaper Rash Thrush Psoriasis Bronchiolitis Asthma Bronchitis
Pneumonia Emphysema Thyroid Problems Diabetes High Cholesterol Heart Problems Heart attack Kidney Problems Prostate Enlargement Arthritis
Glaucoma Migraine High Blood Pressure ENT Surgeries IBS Lupus Rheumatoid Arthritis Food Intolerance TB Valley Fever Histoplasmosis
Coccidiomycosis AIDS Mono Hepatitis **Others (include Surgeries)** _____

BIRTH HISTORY: Bom full term ___ Normal Delivery ___ C-Section ___ Premature ___ Nursed (Breast Fed): No ___ Yes ___ How long ___

No perinatal problems ___ Respiratory Distress at birth ___ Jaundice needing treatment at birth ___ Newborn Sepsis ___

Problems with Reg. Formula ___ Problems with Soy Formula ___ Problems with baby foods _____

FAMILY HISTORY:

Relation _____ Illness (include Allergies / Sinus Conditions / Asthma / Emphysema) _____ Since When _____ Present Treatment _____

Father _____

Mother _____

Brother _____

Brother _____

Sister _____

Sister _____

Daughter _____

Daughter _____

Son _____

Son _____

ENVIRONMENTAL HISTORY:

Home: Apartment House **Basement:** No Yes ___ Is it Damp or Dry ?
 Urban/City Rural/Farm/Ranch

Heating System: Central Air/Forced Air Radiator Space Heater Fireplace None

Air Conditioner: Central Window Unit Humidifier Dehumidifier None Other_____

Type of Floors:

Family Room: Carpet Wood Vinyl Other _____

Bedroom: Carpet Wood Vinyl Other _____

Do you have stuffed toys/animals in the bedroom? Yes No

Do you have pets in the bedroom? Yes No

Type of Bed: Water bed Regular bed Bunk bed

Do you have dust mite encasings/covers for the Mattress? Yes No

Box spring? Yes No

Type of Pillows: Feather Polyester Foam Other _____

Do you have dust mite encasings/covers for the Pillows? Yes No

Pets: None Dogs Cats Birds Other _____

How Many? _____

Are they: Outdoor Indoor In the bedroom

Describe any allergy symptoms around your pets _____

Hobbies: Yours _____

Any allergic reactions seen _____

Hobbies of Family members that affect your allergies _____

Social: Do you or Did You Smoke _____ What _____

Age when started? _____ For How Many Yrs.? _____ Age when quit? _____

Any other smokers at home? ___ Yes ___ No Who _____ Indoors ___ Outdoors ___

Do you drink? _____ Social Drinking? _____ Have drinking problems? _____ Any history of drug use? _____

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Insurance Coverage Policy

To accommodate our patients, we have enrolled in numerous insurance plans. With your cooperation, and our assistance, you should be able to receive all of the insurance benefits to which you are entitled.

Each individual in a plan, however, has his/her own Deductibles, Co-Pays and restrictions regarding where and how often services may be rendered.

It is your responsibility to understand your plans guidelines and inform us of any special requirements. Changes in insurance of any kind have to be reported prior to expiration of the insurance on file with us. Not doing so may result in uncovered services. Payment for these services would then become your responsibility in full and to be paid immediately.

I have read and understand the above policy and agree to accept all responsibilities as they arise.

Name of Patient _____

Date of Birth _____

Signature of Insured/Responsible Party

Date

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NOTICE OF PRIVACY PRACTICES REGARDING PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CARE FULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical health information, including medical records, used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives the patient or their legal guardian certain rights to understand control and how personal health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

This notice explains how we are required to maintain the privacy of all medical health information.

Under the "HIPAA" act we may use and disclose medical health information only for treatment, payment and health care operations.

Treatment includes providing, coordinating, or managing health care and related services by one or more health care providers in the office.

Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Health care operations includes the business aspects of running a practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may contact you to provide appointment reminders or information about treatment plans or other health-related benefits and services that may be of interest to you.

We may also create and distribute de-identified health information by removing all references to individuals. Additional uses and disclosures permitted without authorization or an opportunity to object are

1) when legally required, 2) when there are risks to public health, 3) to report abuse neglect or domestic violence, 4) to conduct health oversight activities, 5) for judicial activities and administrative proceedings if expressly authorized by an order of a court or administrative tribunal, 6) for law enforcement purposes, 7) to coroners, funeral directors and for organ donation 8) to prevent or diminish a serious and imminent threat to patient's health or safety of the public 9) for specified government functions relating to military & veterans activities, national security and law enforcement custodial situations and 10) for worker's compensation to comply with worker's compensation laws.

Any other uses and disclosures will be made only with your written authorization, and in the case of a child, the designated legal guardian. You may revoke such authorization in writing and we will honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

The patient and the designated legal guardian, have the following rights with respect to their personal health information:

The right to inspect and copy the personal health information.

The right to request restrictions on certain use and disclosures of personal health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by the patient or designated legal guardian. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it, unless we are notified to remove the restriction in writing.

The right to reasonable requests to receive confidential communications of personal health information from us by alternative means or at alternative locations.

The right to amend your personal health information. We are, however, not required to agree to the amendment.

The right to receive an accounting of disclosures of personal health information.

The right to obtain a paper copy of this notice

This notice is effective as of **APRIL 15, 2003**, and we are required to abide by the terms of the **Notice of Privacy Practices** currently in effect. We have the right to amend the terms of our **Notice of Privacy Practices** and to make the new notice provisions effective for all personal health information that we maintain. We will post and you may request a written copy of a revised **Notice of Privacy Practices** for our offices.

We have assigned Gabriela Perez as our Privacy Officer, please contact her at (805) 658-9500 for any concerns you may have regarding this Notice or complaints you may have regarding our policies and procedures.

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ACKNOWLEDGEMENT

I, _____, acknowledge that I have read a copy
(Patient/Responsible Person)

of the Notice of Privacy of Personal Health Information.

(Patient name)

(Patient/Responsible Person Signature)

Date: _____

(Witness)

Date: _____