Allergy History

Don't Panic! This won't take long and you know all the answers.

Patient's Name: First Last **DOB:** **Age:**

Were you referred by another doctor? ❑Yes ❑ No Name: _____

What **symptom(s)** is your primary concern?

Please check all recurrent symptoms. (Food symptoms next page)

Nasal Symptoms:	**Sinus Symptoms:**	**Chest/Throat Symptoms:**	**Skin Symptoms:**
❑ Runny nose	❑ Post nasal drainage	❑ Wheezing	❑ Itching
❑ Nasal congestion	❑ Frequent throat clearing	❑ Chest tightness	❑ Eczema
❑ Sneezing	❑ Sinus pressure	❑ Shortness of breath	❑ Hives
❑ Itchy eyes	❑ Headache	❑ Cough	❑ Swelling
❑ Watery eyes	❑ Colored nasal mucous	❑ Wheezing with exercise	❑ Blisters
❑ Itchy nose	❑ Stuffy ears	❑ Difficulty breathing at night	❑ Contact allergy
❑ Itchy ears	❑ Frequent sinus infections	❑ Frequent pneumonia	❑ Other
❑ Itchy throat	❑ Bad breath	❑ Throat tightness	_____
❑ Decreased taste or smell	❑ Snoring	❑ Hoarse voice	_____

How long have you had these symptoms?

Nasal _____ Sinus _____ Chest _____ Skin _____

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal _____ Sinus _____ Chest _____ Skin _____

Is there any **seasonal variation** in your symptoms and if so, when are they worse? ❑Yes ❑ No

Nasal _____ Sinus _____ Chest _____ Skin _____

What **medications** have you tried for your allergy symptoms?

Helped No Help

What **environmental triggers** have made your symptoms worse? ❑Mowed grass ❑Windy weather ❑Dust
❑ Spending time out of doors ❑ Moldy places ❑ Sweeping or dusting ❑ Cigarette smoke ❑ Pollen ❑ Insect sting
❑ Exercise ❑ Respiratory infections ❑ Weather changes ❑ Laughing ❑ Cold Air ❑ Nighttime ❑ Stressful events
❑ Animals (specify) _____ ❑ Perfumes, cosmetics, odors, etc. (specify) _____

Have you had a **sinus CT**? ❑Yes ❑ No When? Results

Other physicians seen for this problem? ❑ ENT ❑ Pulmonologist ❑ Dermatologist ❑ Gastroenterologist

Have you had **nasal** or **sinus surgery**? ❑Yes ❑No When? Results

Have you been treated in **urgent care or ER** for asthma? ❑Yes ❑ No **Most Recent**

Have you had allergy **tests**? ❑Yes ❑ No When? Where?

Have you had allergy **shots**? ❑Yes ❑ No When? Where?

Your Environment

How long have you lived in Arizona? _____ **Where else** have you lived? _____

_____ Are you **better or worse** in Az? Better ☐ Worse ☐

Any pets? ☐Yes ☐ No Please List

Are **symptoms worse** when around your pet? Yes ☐ No ☐ Any **previous pets** in the home? ☐Yes ☐No

Any **smokers** in the home? ☐Yes ☐ No Does your home have a **swamp cooler**? ☐Yes ☐ No

Type of Home: ☐ Appartment/Condo. ☐House Has your home had **water or flood damage** ☐Yes ☐ No

What kind of work do you do? _____ Are symptoms worse at work? ☐Yes ☐ No

Have you **travelled out of the country** in the past year? ☐Yes ☐No Where? _____

Are there **other households** you visit frequently? ☐Yes ☐No Explain: _____

Family members with allergies/asthma? ☐ Mother_____ ☐ Father _____ ☐ Siblings _____

Please list **all current medications** including inhalers, over the counter medications, vitamins, and supplements

_____

_____

_____

_____

Any **medications that you do not tolerate**? ☐Yes ☐No If yes, list the medications and the reaction they caused

_____

_____

_____

Any **foods that you do not tolerate** ☐Yes ☐No If yes, list the foods and the reaction they cause

Medical History (check all that apply)

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Frequent nose bleeds
- ☐ Nasal polyps
- ☐ Migraine headaches
- ☐ Pituitary disorder
- ☐ Thyroid disorder
- ☐ High blood pressure
- ☐ Coronary artery disease
- ☐ Irregular heart beat
- ☐ Enlarged heart
- ☐ Lung disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Seizure disorder
- ☐ Acid reflux
- ☐ Irritable bowel
- ☐ Inflammatory bowel
- ☐ Diabetes
- ☐ Cancer
- ☐ Depression
- ☐ Anxiety

Other: (Please List)

Do you now or have you ever **smoked**? ☐Yes ☐No How much/ how long? _____

Additional information you would like to mention:

Arizona Allergy & Asthma Specialists
16611 South 40th Street, Suite 170
Phoenix, AZ 85048 480-705-8844
Registration Form *Please Print*

Date _____ Home Phone _____ Work Phone _____ Cell Phone _____

Patient _____
Last Name First Initial

Responsible Party (If a minor) _____

Street Address _____

City _____ State _____ Zip _____

Email _____ Referred by _____ If student, name of school _____

Sex ☐ M ☐ F Age _____ Birth Date __/__/__ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient employed by _____ Occupation _____

Who is responsible for this account? (*Who pays the bills?*) ☐ Self ☐ Other (name, address, relationship to patient)

_____

Do you have medical insurance? ☐ Yes ☐ No Primary Insurance Company _____ Secondary _____

Policy Holder _____

Please Read and Sign the Following Office Policies

Assignment of Insurance Benefits
The undersigned hereby authorizes the release of information to referring physicians and any interested party for the purpose of medical claim processing. The undersigned also authorizes payment of medical benefits directly to Arizona Allergy & Asthma Specialist, P.C. and accepts financial responsibility for all charges incurred.

_____
Signature of Insured/Guardian *Date*

Insufficient Fund Policy
I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payment thereafter and I will be obligated to pay a returned check fee of $30.00.

_____
Signature of Insured/Guardian *Date*

Cancellation Policy
I understand and agree that I will give 24 hours notice if unable to make a scheduled appointment. A charge of $50.00 will be assessed to my account for missed or broken appointments without 24 hrs notice.

_____
Signature of Insured/Guardian *Date*

Notice of Privacy Practices

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**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Signature _____ Date _____

Name of Patient _____

Name and relationship of person we may discuss your health care with:

_____