REGISTRATION
Allergy, Sinus & Asthma Consultants, Inc.

Amit Patel, M.D. **Heena Shah, M.D.**

1282 W. Arrow Highway, Ste 100
Upland, CA. 91786
(909) 931-4034 FAX (909) 931-2477

6377 Riverside Ave, Ste B101
Riverside, CA. 92506
(951) 774-2755

Patient's Name: _____Sex: _____ DOB: _____ Marital Status: _____

Address: _____ City: _____ Zip: _____

Cell#: _____ Home #: _____ Email address: _____

Please circle **preferred** method of contact: Phone E-mail Patient portal

Patient's Employer: _____ Phone: _____

Employer Address: _____City: _____Zip: _____

Race (please circle): Caucasian/ African American / Asian / Asian Pacific Islander / Multi-racial / American Indian / Other / Decline

Ethnicity: Hispanic / Latino: ___ Non-Hispanic or Latino: ___Declined: ___ **Primary language spoken**: _____

Name of <u>both</u> parents (if patient is a minor): _____ (Mother) _____ (Father)

Name of nearest relative or friend not living with you: _____

Best Contact Tel:_____ State of Residence: _____ Relationship: _____

Primary Doctor Name: _____ **Telephone Number:** _____

Referred by: PCP ___ENT ___ Pulm ___ Derm ___ Friend___ Internet ___ YELP ___ Other ___

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of PRIMARY Insurance Company: _____

ID#: _____ Group: _____ Circle: PPO or HMO

Policy Holder's Name:_____ Date of Birth: _____Relationship to patient: _____

Address: _____ City: _____ Zip: _____ Phone: _____

Policy Holder's Employer:_____ Phone: _____

SECONDARY INSURANCE:

Name of SECONDARY Insurance Company: _____

ID#: _____ Group: _____ Circle: PPO or HMO

Policy Holder's Name: _____ Date of Birth: _____Relationship to patient: _____

Address: _____City: _____ Zip: _____ Phone: _____

PHARMACY INFORMATION

Name of Regular Pharmacy: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Name of Mail-in Pharmacy: _____ Phone: _____

HIPPA PRIVACY RULE OF PATIENT AUTHORIZATION & PAYMENT AGREEMENT

Allergy, Sinus, and Asthma Consultants, Inc.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (**Patient's Name**) understand that as part of my health care, Allergy, Asthma & Sinus Consultants, Inc., originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and procedure information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care procedures such as assessing quality and reviewing the competence of health care professionals

If I wish, I can be provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information used and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Allergy, Asthma & Sinus Consultants, Inc.'s notice to prior signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (§164.506(a))

I understand that: I have the right to review Allergy, Asthma & Sinus Consultants, Inc.'s notice of information practices prior to signing this consent;

- That Allergy, Asthma & Sinus Consultants, Inc.'s office, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Allergy, Asthma & Sinus Consultants, Inc.'s office, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Allergy, Asthma & Sinus Consultants, Inc.'s office has already taken action in reliance thereon.

HIPPA Consent & Payment Agreement

HIPPA Laws passed by the Federal Government, protect your privacy. We cannot release any information or discuss your care or account with anyone without your specific written permission. The HIPPA Act requires that you include information of whom we may release ANY information to. IF YOU WISH NO ONE TO BE ALLOWED ACCESS PLEASE STATE NO ONE! We will discuss information with no one but the patient or patient's legal guardian. The patient is responsible for all fees, regardless of insurance coverage. I hereby assign to Allergy, Asthma & Sinus Consultants, Inc., all payments for medical services rendered to myself or my dependents.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

I further agree in the event of nonpayment, to bear the cost of collections, and or court costs and reasonable legal fees should this be required. I also authorize the release of any medical information or records needed for my care to other Physicians/Labs or anyone necessary to process this claim. Unless specified above, we may discuss your account and/or records with family members.

PRINTED NAME of Patient or Legal Representative _____

SIGNATURE of Patient or Legal Representative _____

Relationship to Patient _____ **Date:** _____

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Please RELEASE and SEND Medical Information Requested to:

MEDICAL RECORDS RELEASE/ REQUEST INFORMATION FROM:

Name of Medical Group / Clinic / Hospital: _____
Name of Health Care Provider: _____
Address: _____
City / State / Zip Code: _____
I hereby authorize _____ to release and disclose the medical records and information as requested below to **Amit Patel M.D, Heena Shah M.D.** and their staff.

Release records and information for:

_____ _____ _____/_____/_____
Name of Patient **Medical Records / Soc. Sec. #** **Date of Birth**

_____
Address City State Zip code

DURATION: This authorization is effective immediately and shall remain in effect until _____ or one year from the date of signature.
REVOCATION: This authorization can be revoked in writing by the patient at any time prior to the release of information.
RE- DISCLOSURE: I understand that the requester may not lawfully use or disclose the received information unless a new authorization is requested and signed by me, unless permitted by law.

SPECIFY RECORDS TO BE RELEASED

___General Medical Information from _____ to _____
___Information regarding specific Treatment _____ to _____
___Imaging (X – rays / CT scan / MRI) Reports
___Pulmonary Function Tests (PFTs) from _____ to _____
___General LAB results from _____ to _____
___Allergy Testing, Lung function, Allergy Care summary from _____ to _____
___OTHER _____

I request that the health information released and / or disclosed as specified by this authorization be used for the following purposes only: _____

I further **WISH** this information to be shared with **ONLY** _____

A copy of this authorization is as valid as an original document.

SIGNED:_____

DATE: _____

Allergy, Sinus and Asthma Consultants, Inc.

Amit Patel, M.D. **Heena Shah, M.D.**

CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD:_____

BILLING ADDRESS:

_____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD # LAST 4 DIGITS _____ ***(THE CARD WILL BE ENTERED MANUALLY)***

EXPIRATION DATE: _____/_____

VERIFICATION CODE (3 or 4 DIGITS) _____

Please provide additional family members in our office if this card is to be used for services rendered for them as well.

Name_____ **Date of Birth** _____

Name_____ **Date of Birth** _____

Name_____ **Date of Birth** _____

I acknowledge and authorize Allergy, Sinus & Asthma Consultants, Inc to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider.

I acknowledge that my card will be run in the event payment is not received within sixty days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ **Cardholder Signature**

_____ **Date**

Allergy, Sinus & Asthma Consultants, Inc.

Please check, fill in the blanks or circle, as appropriate, as best you can. The physician will go over the questionnaire to obtain more details and clarify any questions.

Name: _____Date: _____ Age: _____ Birthplace: _____
Primary Care Physician: _____ Other Physicians Seen (specialty, name, tel #): _____

PRESENT OR PAST SYMPTOMS INCLUDE: (Check the following and write duration of symptoms):

___Headaches/Migraines/ Sinus Issue	___Loss of Voice/ Hoarseness	___Difficulty Breathing or wheezing
___Tired/Drowsiness/Sleep Apnea	___Frequent Tonsillitis	___Frequent Bronchitis/Pneumonias
___Itching/ Watery/ Burning/Red Eyes	___Yellow or Green Sputum	___Snoring or Mouth Breathing
___Plugging/Itching/Fluid in Ears	___Itchy Throat/Sore throats/Drainage	___Choking, Vomiting, Texture dislike
___Nasal Congestion or Polyps	___Choking in the Throat/Mucus	___Allergic Reaction to Foods
___Runny or Itchy Nose	___Cough (Dry/Productive)	___ Itching
___Sneezing	___Chest Tightness	___Rash/Skin Problems/Swelling

Please explain in detail what your MOST bothersome symptoms are: _____
_____
_____

SYMPTOMS PROVOKED BY:

____Dust	____Smog/Nearby Traffic	____Infections	____Indoors
____Pets (Cats/Dogs)	____Physical exertion	____Foods/Drugs	____Nighttime/Early AM
____Mold	____Grass/Trees/Weeds	____Work exposures	____Outdoors/Farms
____Tobacco Smoke	____Santa Ana Winds	____Perfumes/Fragrances	____Air conditioning
____Weather Changes	____Rain/Humidity	____Sulfites	____Stress

SYMPTOMS RELIEVED BY:

____On Vacation	____In the Mountains	____In the Desert	____Out of So. California
____At the Beach	____On the Weekends	____During Rain	____Indoors

PAST or CURRENT MEDICATIONS (Brand OR Generic) HAVE INCLUDED (please circle):

___**Antibiotics**: _____ # of Lifetime Courses _____ Avg # Courses/12 months
___**Oral or Injectable Steroids**: _____ # of Lifetime Courses _____ Avg # Courses/12 months
__ **Antihistamines/Allergy tablets**: Zyrtec Claritin Allegra Xyzal Benadryl Hydroxyzine Pepcid Zantac Doxepin Singulair Other: _____
___**Decongestants**: Sudafed Afrin Zyrtec-D Allegra-D Claritin-D Mucinex Other: _____
___**Nasal Sprays**: Flonase Nasonex Azelastine Nasocort Rhinocort Sensimist Dymista Patanase Ryaltris Other: _____
___**Topical Treatments**: Hydrocortisone Betamethasone Triamcinolone Clobetasol Mometasone Elidel Protopic Eucrisa Other: _____
___**Inhalers**: Advair Airsupra Arnuity Asmanex Anoro Alvesco Breo Breztri Combivent Dulera Flovent Incruse Pulmicort Qvar Spiriva Stiloto Symbicort Trelegy Utibron Albuterol (Ventolin/Proair/Proventil/Xopenex/Nebulizer)
___**Allergy Shots/Immunotherapy**: Duration (months/years) _____ Which year? _____ Quit _____
___**Immunologic Therapies**: Xolair Nucala Cinqair Dupilimab Fasenra Tezspire GammaGlobulin Other: _____
___**Other Over the Counter or other Prescription Medications**: _____

PREVIOUS INVESTIGATIONS: (PLEASE BRING COPIES OR HAVE YOUR DOCTOR SEND THESE BEFORE YOUR FIRST VISIT)

___ Allergy Skin Testing	Date _____	___ Sinus X-ray or CT scan	Date _____
___ Allergy Blood Tests	Date _____	___ Routine Blood Tests	Date _____
___ Pulmonary Function Test	Date _____	___ Immunologic Testing	Date _____
___ Chest X-ray or CT scan	Date _____	___ Hearing Test	Date _____
___ Autoimmune testing	Date _____	___Biopsies (skin, esophagus, etc)	Date_____

ALLERGY OR INTOLERANCES TO MEDICINES: _____No Known Allergies to Medicine
Name _____ Symptoms _____
Name _____ Symptoms _____

CURRENT MEDICATIONS AND DOSAGES INCLUDE: Hesitation in Taking Medicines _____ List Attached ___

1. _____	5. _____
3. _____	6. _____
2. _____	7. _____
4. _____	8. _____

VACCINATIONS (date last received): Childhood Vaccines Up-to-date? _____
Pneumonia _____ Tetanus _____ Influenza _____ Shingles _____COVID____ RSV ____ Meningitis___

Name: _____Date: _____

PAST MEDICAL HISTORY (Y/N and Circle or Write Specifics):

___No Significant Problems
___Allergy to Airborne Allergens (Seasonal, Hay fever, All Year)
___Anaphylaxis, Angioedema, or Severe Allergic reaction
___Breathing Conditions (Asthma, COPD, Sleep Apnea, etc.)
___Eczema, Hives or other Skin conditions/Dermatitis
___Infections (Bronchitis, Ear, Pneumonia, Sinusitis, Skin, Tonsillitis, UTI, Abscesses, etc.)
___Nasal, Ear or Sinus Problems (Deviated septum, polyps, etc.)
___Cardiac Condition (Aneurysm, Heart Attack, High Chol, High Blood Pressure, Pericarditis, POTS, etc)
___Endocrine Condition (Diabetes, Osteoporosis, Thyroid, etc.)
___Eye Condition (Glaucoma, cataracts, conjunctivitisetc.)
___Gastrointestinal Condition (Celiac Disease/Diarrhea, GERD/Reflux, Eosinophilic Esophagitis/Vomiting)
___Headaches/migraines or Weight Changes
___Hematologic Condition (Deep vein thrombosis, pulmonary embolism, clotting disorder)
___Kidney or Prostate Disease
___Liver or Spleen Disease
___Malignancy (Cancer, Lymphoma, Leukemia, etc.) & Treatment (Radiation/Chemotherapy)
___Neurologic condition (stroke, TIA, etc.)
___Orthopedic Conditions
___Psychiatric Condition (Anxiety, Depression, etc.)
___Rheumatologic Condition (Lupus, RA, Sjogren's)
___Mast cell disorders (MCAS, mastocytosis)
Other _____

Previous hospitalizations: REASON_____# of times _____last_____
Previous ER/Urgent care: REASON_____# of times _____last_____
Previous ICU admissions: REASON_____# of times _____last_____
Previous need for ventilator # of times _____

FAMILY HISTORY (Do your parents (m/f), grandparents (gm/gf), siblings (b/s) or children (s/d) have any of the following conditions or please specify any other medical conditions below):

_____No History of Allergic Disease
_____Hay Fever/Allergies
_____Sinus Disease
_____Skin Condition
_____Food Allergy
_____High Blood Pressure
_____Thyroid Problems
_____Family History is Unknown
_____Immune Deficiency
_____Contact Dermatitis
_____Hives or Swelling
_____Atopic Dermatitis
_____Diabetes
_____Cancer/Leukemia/Lymphoma
_____Lung Condition: Asthma, COPD, Emphysema
_____Cystic Fibrosis or Alpha-1- Antitrypsin Def
_____Pneumonia or Recurrent Infections
_____Nasal Polyps
_____Autoimmune
_____Heart Disease
_____Glaucoma/Cataracts
Other Familial Medical Problems _____

PAST SURGICAL HISTORY:

___NO prior surgeries
___Sinus Drainage Procedure
___Endoscopic Sinus Surgery
___Nasal Polypectomy
___Septoplasty/Deviated Septum
___PE Tubes in Ears
___Tonsillectomy
___Adenoidectomy
___Hernia Repair
___Hysterectomy
___Appendectomy
___Orthopedic Surgery
___Heart or Lung Surgery
___Cancer Surgery
___Gallstone Removal
___Eye Surgery
___Thyroid Removal
___Other_____

SOCIAL HISTORY:

Current and Previous Residences: _____
How Long in Southern California _____ Years _____ Months
Bedroom Environment: Pets sleep in bedroom ____ Dust Control Measures ____Stuffed Animals ____ HEPA filter ___Other _____
Work Environment: Present Occupation _____ Retired (Y/N) _____ Disabled, why? _____
Exposures at work? _____ Previous Occupations _____Years Worked _____
Infant/Child Environment: Spends the Day: _____ At Home _____ Preschool _____ Daycare _____ Other _____
Performance in School: _____ Behavior Problems _____**# of Days Missed from School/Work, why**? _____
Substance Use: Alcohol intake, Type and Amount _____**Use of Illicit Drugs, Past or Present** _____
TOBACCO SMOKE: PAST OR PRESENT 2nd HAND EXPOSURE (Indoor or Outdoor) _____PACKS/DAY _____ YEARS OF USE____ QUIT, WHEN? _____**HOBBIES**: _____

REVIEW OF SYSTEMS:

No Problems: _____
Eye Problems: _____
Ear Problems: _____
Heart Problems: _____
Immune Problems: _____
Lung Problems: _____
Muscle and Joint Problems: _____
Nasal Problems: _____
Neurological Problems: _____
Stomach/Intestinal Problems: _____
Skin Problems: _____
Thyroid/Diabetes Problems: _____
Psychiatric Problems: _____
Weight Loss or Gain/Fatigue: _____