

REGISTRATION

Allergy, Sinus & Asthma Consultants, Inc.

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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 both 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:** _____

Allergy, Sinus & Asthma Consultants, Inc.

Instructions on Filling in Questionnaire

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):

<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Chest Tightness
<input type="checkbox"/> Sinus Pressure	<input type="checkbox"/> Loss of Voice/ Hoarseness	<input type="checkbox"/> Difficulty Breathing or wheezing
<input type="checkbox"/> Tired/Drowsiness/Sleep Apnea	<input type="checkbox"/> Frequent Tonsillitis	<input type="checkbox"/> Frequent Bronchitis/Pneumonias
<input type="checkbox"/> Itching/ Watery/ Burning/Red Eyes	<input type="checkbox"/> Yellow or Green Sputum	<input type="checkbox"/> Snoring or Mouth Breathing
<input type="checkbox"/> Plugging/Itching/Fluid in Ears	<input type="checkbox"/> Itchy Throat/Sore throats/Drainage	<input type="checkbox"/> Allergy to Insects
<input type="checkbox"/> Nasal Congestion or Polyps	<input type="checkbox"/> Choking in the Throat/Mucus	<input type="checkbox"/> Allergic Reaction to Foods
<input type="checkbox"/> Runny or Itchy Nose	<input type="checkbox"/> Cough (Dry/Productive)	<input type="checkbox"/> Rash/Skin Problems/Swelling

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

SYMPTOMS PROVOKED BY:

<input type="checkbox"/> Dust	<input type="checkbox"/> Smog/Nearby Traffic	<input type="checkbox"/> Infections	<input type="checkbox"/> Indoors
<input type="checkbox"/> Pets (Cats/Dogs)	<input type="checkbox"/> Physical exertion	<input type="checkbox"/> Foods/Drugs	<input type="checkbox"/> Nighttime/Early AM
<input type="checkbox"/> Mold	<input type="checkbox"/> Grass/Trees/Weeds	<input type="checkbox"/> Work exposures	<input type="checkbox"/> Outdoors/Farms
<input type="checkbox"/> Tobacco Smoke	<input type="checkbox"/> Santa Ana Winds	<input type="checkbox"/> Perfumes/Fragrances	<input type="checkbox"/> Air conditioning
<input type="checkbox"/> Weather Changes	<input type="checkbox"/> Rain/Humidity	<input type="checkbox"/> Sulfites	<input type="checkbox"/> Stress

SYMPTOMS RELIEVED BY:

<input type="checkbox"/> On Vacation	<input type="checkbox"/> In the Mountains	<input type="checkbox"/> In the Desert	<input type="checkbox"/> Out of So. California
<input type="checkbox"/> At the Beach	<input type="checkbox"/> On the Weekends	<input type="checkbox"/> During Rain	<input type="checkbox"/> 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 Other: _____
 Topical Treatments: Hydrocortisone Betamethasone Triamcinolone Clobetasol Mometasone Elidel Protopic Eucrisa Other: _____
 Inhalers: Advair Arnuity Asmanex Anoro Alvesco Breo 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 Fasentra 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)

<input type="checkbox"/> Allergy Skin Testing	Date _____	<input type="checkbox"/> Sinus X-ray or CT scan	Date _____
<input type="checkbox"/> Allergy Blood Tests	Date _____	<input type="checkbox"/> Routine Blood Tests	Date _____
<input type="checkbox"/> Pulmonary Function Test	Date _____	<input type="checkbox"/> Immunologic Testing	Date _____
<input type="checkbox"/> Chest X-ray or CT scan	Date _____	<input type="checkbox"/> Hearing Test	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 _____

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

- | | |
|---|--|
| <input type="checkbox"/> No Significant Problems | <input type="checkbox"/> Headaches/migraines or Weight Changes |
| <input type="checkbox"/> Allergy to Airborne Allergens (Seasonal, Hay fever, All Year) | <input type="checkbox"/> Hematologic Condition (Deep vein thrombosis, pulmonary embolism, clotting disorder) |
| <input type="checkbox"/> Anaphylaxis, Angioedema, or Severe Allergic reaction | <input type="checkbox"/> Kidney or Prostate Disease |
| <input type="checkbox"/> Breathing Conditions (Asthma, COPD, Sleep Apnea, etc.) | <input type="checkbox"/> Liver or Spleen Disease |
| <input type="checkbox"/> Eczema, Hives or other Skin conditions/Dermatitis | <input type="checkbox"/> Malignancy (Cancer, Lymphoma, Leukemia, etc.) & Treatment (Radiation/Chemotherapy) |
| <input type="checkbox"/> Infections (Bronchitis, Ear, Pneumonia, Sinusitis, Skin, Tonsillitis, UTI, Abscesses, etc.) | <input type="checkbox"/> Neurologic condition (stroke, TIA, etc.) |
| <input type="checkbox"/> Nasal, Ear or Sinus Problems (Deviated septum, polyps, etc.) | <input type="checkbox"/> Orthopedic Conditions |
| <input type="checkbox"/> Cardiac Condition (Aneurysm, Heart Attack, High Chol, High Blood Pressure, Pericarditis) | <input type="checkbox"/> Psychiatric Condition (Anxiety, Depression, etc.) |
| <input type="checkbox"/> Endocrine Condition (Diabetes, Osteoporosis, Thyroid, etc.) | <input type="checkbox"/> Rheumatologic Condition (Lupus, RA, Sjogren's) |
| <input type="checkbox"/> Eye Condition (Glaucoma, cataracts, conjunctivitis etc.) | Other _____ |
| <input type="checkbox"/> Gastrointestinal Condition (Celiac Disease/Diarrhea, GERD/Reflux, Eosinophilic Esophagitis/Vomiting) | |

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):

- | | | |
|---|--|--|
| <input type="checkbox"/> No History of Allergic Disease | <input type="checkbox"/> Family History is Unknown | <input type="checkbox"/> Lung Condition (Asthma, COPD, Emphysema) |
| <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Cystic Fibrosis or Alpha-1- Antitrypsin Def |
| <input type="checkbox"/> Sinus Disease | <input type="checkbox"/> Contact Dermatitis | <input type="checkbox"/> Pneumonia or Recurrent Infections |
| <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Hives or Swelling | <input type="checkbox"/> Nasal Polyps |
| <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Atopic Dermatitis | <input type="checkbox"/> Autoimmune |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer/Leukemia/Lymphoma | <input type="checkbox"/> Glaucoma/Cataracts |
| Other Familial Medical Problems _____ | | |

PAST SURGICAL HISTORY:

- | | | |
|--|---|--|
| <input type="checkbox"/> NO prior surgeries | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Heart or Lung Surgery |
| <input type="checkbox"/> Sinus Drainage Procedure | <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Cancer Surgery |
| <input type="checkbox"/> Endoscopic Sinus Surgery | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Gallstone Removal |
| <input type="checkbox"/> Nasal Polypectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Septoplasty/Deviated Septum | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Thyroid Removal |
| <input type="checkbox"/> PE Tubes in Ears | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> 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, 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: _____ | Nasal Problems: _____ |
| Eye Problems: _____ | Neurological Problems: _____ |
| Ear Problems: _____ | Stomach/Intestinal Problems: _____ |
| Heart Problems: _____ | Skin Problems: _____ |
| Immune Problems: _____ | Thyroid/Diabetes Problems: _____ |
| Lung Problems: _____ | Psychiatric Problems: _____ |
| Muscle and Joint Problems: _____ | Weight Loss or Gain/Fatigue: _____ |