

PATIENT INFORMATION		
Patient #:	Gender:	Date of Birth:
Last Name:		Age:
First Name:	Initial:	Social Security #:
Address:		Home Phone:
City, State, Zip:		Work Phone:
RESPONSIBLE PARTY		
Account #	Patient Relationship to Guarantor:	
Last Name:	Gender:	Marital Status:
First Name:	Date of Birth:	
Address:		Social Security #:
City, State, Zip:		Home Phone:
Employer:	Work Phone:	
Employer Address:	City, State Zip:	
Primary Care Physician:	Telephone #:	
INSURANCE INFORMATION		
Primary Insurance:		Policy/Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:
Secondary Insurance:		Policy Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:
PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION		
Parent/Legal Guardian Name:		Emergency Contact:
Address(if different than patient):		Address(if different than patient):
		Patient relationship to Contact:
Parent Home Phone:		Contact Home Phone:
Parent Work Phone:		Contact Work Phone:
MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION		
<p>I hereby authorize Arizona Asthma and Allergy Institute to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges, I hereby authorize Arizona Asthma and Allergy Institute to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and effect until revoked in writing by me.</p>		
X _____ Signature		Date: _____

Arizona Asthma & Allergy Institute

New Patient History Form

5605 W. Eugie, Suite 200
Glendale, Arizona 85304-1200

9220 E. Mountain View, Suite 200
Scottsdale, Arizona 85258-4715

4001 E. Baseline Rd Suite 201
Gilbert, AZ 85234

13026 W. Rancho Sante Fe Blvd. Suite A-100
Avondale, AZ 85323

NAME _____ AGE _____ DATE _____

DATE OF BIRTH _____ SEX _____

PATIENT'S REGULAR DOCTOR _____ Referred by _____

WHAT PROBLEMS DO YOU WANT EVALUATED (Circle)

1. Hay fever or nasal problems
2. Eye symptoms
3. Sinus and/or Ear problems
4. Breathing difficulties- Asthma, bronchitis, cough, etc.
5. Skin problems- Hives or swelling, eczema, or other rash
6. Insect reaction (local swelling)
7. Drug reaction
8. Food reaction
9. Headaches
10. Other

WHAT ARE YOUR SYMPTOMS (Circle appropriate symptoms)

Nasal Symptoms

- how many years?
- nasal discharge- clear, yellow, green
- post nasal drip
- sneezing
- nasal itchiness
- nasal congestion
- frequent nose blowing
- loss of smell/taste
- throat itchiness
- daily, weekly, seasonal?

Sinus Symptoms

- frequent sinus infections
- facial pain and tenderness
- tooth pain
- pressure and congestion
- colored nasal discharge
- headaches

Chest Symptoms

- cough, wheeze, shortness of breath
- how long?
- daily, weekly, or monthly?
- chest tightness
- waking up at night
- how many nights per week?
- do you cough up anything? What color?
- have you tried any inhalers or albuterol?
- do you have a nebulizer or breathing machine?
- do you have a peak flow meter?
- how many severe episodes in the last year?
- have you used prednisone or oral steroids?
- have you been to the emergency room?
- have been hospitalized for the chest symptoms? When?
- do you have stomach reflux?
- do you have problems with exercise?

Eye Symptoms

- itchiness, redness, puffiness
- watery discharge
- eyelid irritation
- dark circles under eyes
- do you use eye drops?

Skin symptoms

- hives, welts, red patches, itchiness
- eczema
- areas of swelling
- how long?
- family history of swelling or eczema?
- recent infection?
- recent antibiotic use?

WHAT TRIGGERS YOUR SYMPTOMS ? (Circle) (Beside each circled item, N=nasal, C=chest)

ALLERGIES

- pollens (grass, weeds, trees) N C
- animals (cat, dog, horse) N C
- mold/mildew N C
- dust N C
- foods N C

INFECTION

- viral colds N C
- sinus infection N C

OTHER

- antibiotics N C
- aspirin N C
- chemicals N C
- insects N C
- other

IRRITANTS

- weather changes N C
- wind N C
- cold air/humidity N C
- exercise N C

IRRITANTS

- woodstove/fireplace N C
- strong odors N C
- perfumes/chemicals N C
- tobacco smoke N C

UNKNOWN

- emotions N C
- stress N C
- laughter N C
- crying N C

Patient Name _____

CIRCLE WHICH MONTHS YOU HAVE SYMPTOMS

Nose/Ears JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Sinus JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Breathing JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Skin JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

ENVIRONMENTAL HISTORY (Circle)

Current residence: city _____ Length at this location _____

Previous locations: _____

Resident type: House Condo Apt Mobile home

Landscaping: Desert Grass Trees Decorative gravel / rock

Neighborhood: Residential Rural Agricultural Industrial Business

Heating: Gas Electric Wood stove Other

Cooling: Air conditioning Swamp cooler Central Room only None Other

Allergen air filtration: None Small bedside Electronic HEPA

Smokers at home? N Y If yes, who: _____

Flooring: Carpet Tile Wood Linoleum Area rugs Concrete

Bedroom: Box spring mattress Waterbed Bunk bed Futon Mattress covered in plastic

Pillows: Polyester Foam Feather None

Animal Exposure: None Cat Dog Horse Rabbit Hamster Gerbil Bird

In bedroom In House Outside only Parents/Baby sitters

Work: Type of work _____ Number of work days missed over the past 12 months _____

Are your symptoms worse at work? N Y Describe _____

School: Daycare Elementary Junior High High School College

Number of school days missed over the past 12 months _____

Are your symptoms worse at school? N Y Describe _____

If daycare- is there exposure to: animals wood stoves tobacco smoke

CURRENT MEDICATIONS (List medicines taken for any reason including aspirin, blood pressure, thyroid, nose sprays, etc.)

Name of medication	Dose	How often taken	Additional medications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIOR ALLERGIC REACTIONS

Drug Reaction: Medication _____ Reaction _____
Medication _____ Reaction _____
Medication _____ Reaction _____

Insect Reaction: Insect type _____ Reaction _____
When did this occur? _____
Symptoms: tongue or throat swelling hives shortness of breath wheeze local swelling

Food Reaction: What were you eating? _____
Time from eating to onset of reaction? _____
Symptoms: tongue or throat swelling hives nausea vomiting diarrhea shortness of breath wheeze

PREVIOUS ALLERGY CARE (Circle those that apply)

- Never tested before
- Tested before: skin tests blood tests
Negative Positive Grass Weeds Trees Dust Animals Molds Foods
- Allergy shots? N Y If yes, name of doctor and locations _____
Dates _____ to _____ Degree of help: None Slight Moderate Great
- Previous sinus x-ray or CT scan?
- Previous ENT or Pulmonary evaluation?
- Previous CXR?

Patient Past Medical, Family, and Social History

Have you had any of the following	<u>Yes</u>	<u>No</u>	<u>Describe the problem when appropriate</u>
1. Abnormal chest x-ray			_____
2. Anesthesia complications			_____
3. Anxiety, depression or mental illness			_____
4. Blood problems (abnormal bleeding or anemia)			_____
5. Diabetes			_____
6. Growth removed from the colon or rectum			_____
7. Hepatitis			_____
8. High blood pressure			_____
9. High cholesterol or triglycerides			_____
10. Sexually transmitted disease			_____
11. Stroke or TIA			_____
12. Treatment for alcohol and/or drug abuse			_____
13. Tuberculosis or positive tuberculin skin test			_____
14. Cosmetic or plastic surgery			_____

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check(✓) in the following appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. (Circle) the appropriate choice when multiple choices are listed in a question:

	<u>Medical Problem</u>	<u>Surgery</u>	<u>Year(s) of Surgery</u>	<u>Describe</u>
1. Eyes (cataracts, glaucoma)			_____	_____
2. Ears, nose, sinuses, or tonsils			_____	_____
3. Thyroid or parathyroid glands			_____	_____
4. Heart valves or abnormal heart rhythm			_____	_____
5. Coronary (heart) arteries (angina)			_____	_____
6. Arteries (aorta, arms, legs)			_____	_____
7. Veins or blood clots in the veins			_____	_____
8. Lungs (pneumonia, valley fever)			_____	_____
9. Esophagus or stomach (ulcer, reflux)			_____	_____
10. Bowel or appendix			_____	_____
11. Liver or gallbladder			_____	_____
12. Pancreas			_____	_____
13. Hernia			_____	_____
14. Lymph nodes or spleen			_____	_____
15. Kidneys or bladder			_____	_____
16. Bones, joints or muscles			_____	_____
17. Back, neck or spine			_____	_____
18. Brain (headaches, seizures, depression)			_____	_____
19. Skin			_____	_____
20. Females: breasts, uterus, tubes, ovaries			_____	_____
21. Males: prostate, testes, vasectomy			_____	_____

Pediatric History (Please fill out this section if patient is <12 years old)

Pregnancy: Full term Preterm Describe _____
 Complications during pregnancy _____
 Labor and delivery: Normal Complications Describe _____
 Newborn nursery course: Normal Complications Describe _____
 Growth and development: Normal Complications Describe _____
 Immunizations up to date: Yes No
 History of RSV infection?

Patient Name _____

FAMILY MEDICAL HISTORY (Indicate any medical, allergic, or respiratory disorders)

Mother _____
Father _____
Brother/Sister _____
Grandparents _____
Other _____

SOCIAL HISTORY

Education: How many years of school have you completed? _____

Occupations: Your current employment status: Employed Retired Homemaker Student Unemployed
Employed-current occupation(s): _____
Previous Occupations/Jobs: _____
Spouses Employment _____
Parent's Employment _____

Disability: Are you disabled: No Yes _____

Abuse: Have you ever been physically, sexually, or emotionally abused? No Yes _____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used	Type/Amount/Frequency	How Long? (Years)	If stopped, when?(Years)
Tobacco	Yes No	Yes No			
Alcohol-beer wine, liquor	Yes No	Yes No			
Caffeine-coffee, tea, soda	Yes No	Yes No			
Recreational/Street drugs	Yes No	Yes No			

Marital Status: Are you currently married? No Yes In what year did this marriage occur? _____

List any previous marriages (year married and duration): _____

Current Spouse: Not applicable Alive (Name _____) Deceased

Health problems or cause of death: _____

Reviewed and annotated by: (Physician only)

Signature	Date	Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS

Form 201

Patient Name _____

Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking Yes or No for each question. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question. If yes, please explain.

- | | <u>YES</u> | <u>NO</u> | Notation |
|---|------------|-----------|----------|
| 1. Skin rash, hives, itchiness, dry skin? | | | _____ |
| 2. <u>Unhealing sores, excessive bruising or change of a mole</u> | | | _____ |
| 3. Excessive thirst or urination? | | | _____ |
| 4. Weight gain or loss, cold intolerance, or tremor? | | | _____ |
| 5. <u>Change in sexual drive or performance?</u> | | | _____ |
| 6. Significant headaches, seizures, blurred speech or difficulty moving an arm or leg? | | | _____ |
| 7. <u>Numbness or tingling of hands or feet?</u> | | | _____ |
| 8. Eye problems such as double vision, cataracts or glaucoma? | | | _____ |
| 9. Diminished hearing, dizziness, hoarseness, sinus problems or nasal polyps? | | | _____ |
| 10. <u>Do you wear dentures? (If yes: Full Upper Lower Partial)</u> | | | _____ |
| 11. Bothered with cough, shortness or breath, wheezing or asthma? | | | _____ |
| 12. Coughing up sputum or blood? | | | _____ |
| 13. <u>Exposed to anyone with tuberculosis</u> | | | _____ |
| 14. Blacked out or lost consciousness? | | | _____ |
| 15. Chest pain or pressure, rapid or irregular heart beats | | | _____ |
| 16. Awakening at night with shortness or breath? | | | _____ |
| 17. Abnormal swelling in the legs or foot? | | | _____ |
| 18. <u>Pain in the calves of your legs when you walk?</u> | | | _____ |
| 19. Difficulty with swallowing, heartburn, nausea, vomiting or stomach trouble? | | | _____ |
| 20. Problems with constipation, diarrhea, blood/changes in bowel movement? | | | _____ |
| 21. Have you had a colon or rectum x-ray? | | | _____ |
| 22. <u>Have you undergone protoscopy, sigmoidoscopy, or colonoscopy?</u> | | | _____ |
| 23. Difficulty starting your urinary stream or completely emptying your bladder? | | | _____ |
| 24. Leaking urine or blood in the urine? | | | _____ |
| 25. <u>Burning sensation or pain with urinating</u> | | | _____ |
| 26. <u>Pain, stiffness or swelling in your back, joints or muscles?</u> | | | _____ |
| 27. Fever within the last month? | | | _____ |
| 28. <u>Enlarged glands (lymph nodes)?</u> | | | _____ |
| 29. Experiencing an unusually stressful situation? | | | _____ |
| 30. Weight gain or loss of more than 10 pounds during the last 6 months? | | | _____ |
| 31. Problems falling asleep, staying asleep, sleep apnea or disruptive snoring? | | | _____ |
| 32. <u>Abnormal nipple discharge or a breast lump?</u> | | | _____ |
| 33. Have you every felt a need to cut down on your alcohol consumption? | | | _____ |
| 34. Do relatives/friends worry or complain about your alcohol consumption? | | | _____ |
| 35. <u>Have you been physically, sexually, or emotionally abused?</u> | | | _____ |
| QUESTIONS 36-43 TO BE ANSWERED BY FEMALE PATIENTS ONLY: | | | |
| 36. Have you ever had an abnormal Pap smear? Unknown | | | _____ |
| 37. Have you experienced menopause or had a hysterectomy? | | | _____ |
| 38. If no: Are you concerned about your menstrual periods? | | | _____ |
| 39. Might you be pregnant at this time? | | | _____ |
| 40. Date or onset of your last menstrual period: <u>mo:</u> <u>day:</u> <u>yr:</u> _____ | | | _____ |
| 41. Approximate date of your last Pap smear or pelvic exam: <u>mo:</u> <u>day:</u> <u>yr:</u> _____ | | | _____ |
| 42. Approximate date of your last mammogram: <u>mo:</u> <u>day:</u> <u>yr:</u> _____ | | | _____ |
| 43. Number of: Pregnancies _____ Live Births _____ Miscarriages/abortions _____ | | | _____ |

Reviewed and annotated by: (Physician only)

Signature	Date	Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Acknowledgement of Receipt of Privacy Notice
Original to be maintained in Patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Printed Patient Name

Acct#

Patient or legally authorized individual signature

Date

Relationship
(parent, legal guardian,
personal representative, etc.)



FINANCIAL POLICY

Our office files primary insurance as a courtesy for all of our patients. **Please bring your insurance card with you and keep our office informed of all insurance changes and special authorization requests.** Payment is expected at the time of service by cash, check, VISA, MC, American Express or Discover. Patients are responsible for the appropriate deductible and co-insurance. For members of health plans in which we participate the appropriate deductible, co-pay, or patient's portion will be collected. Your insurance is a contract between you and your insurance company. You are **responsible** for all bills regardless of the type of insurance coverage you may have. Please contact your insurance company to verify coverage for our services. We allow 60 days for your insurance carrier to pay. After that time the unpaid balance is due to payable by the patient.

You are expected to pay all charges in full at the time of service if:

1. You have no insurance coverage.
2. You prefer to file your own insurance.
3. Your insurance carrier sends payment directly to you.
4. Insurance benefits cannot be verified by our office.
5. Proper authorization/referral has not been received.

DELINQUENT ACCOUNTS

1. Accounts past due will be placed on a COD status at which time all charges must be paid in full at each visit until account is brought current.
2. Accounts past due are subject to collection. All fees including, but not limited to collection fees, attorney fees and court fees incurred shall become your responsibility in addition to the balance due this office.

RETURNED CHECKS

There is a \$25.00 service fee on all returned checks. Returned checks must be redeemed with certified funds (cashier's check, money order, cash).

PRESCRIPTION REQUESTS

Any non-emergency prescription requests after the office has closed will be subject to a \$7.00 charge.

MINOR PATIENTS

We require that a minor patient be accompanied by an adult (parent or legal guardian). The adult accompanying the minor patient is required to pay in accordance with our policies. We do not accept third party assignments nor do we recognize or enforce the terms of divorce decrees.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY THE TERMS OF THIS POLICY.

PATIENT NAME (please print)

SIGNATURE (Responsible Party)

Rev (8/01)

DATE

Patient No-Show / Cancellation Policy

In keeping with our goal to provide each patient with the highest standard of care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. “No-shows” or last minute cancellations leave empty appointment times for other patients in need of medical care. For this reason, a fee of \$25 may be imposed for missed or cancelled appointments with less than 24 hours notice.

Please note that no-show/late cancellation fees are patient responsibility and will not be billed to your insurance company.

Thank you in advance for your consideration and for allowing us to partner in your healthcare needs.