Redding Allergy & Asthma Center

MEDICAL HISTORY

Name:______________________________ Date of Birth:___________

What is your main reason for seeing us today?____

When is the last time you took an antihistamine (Benadryl, Zyrtec, Claritin, Allegra, etc)___________________

Have you been experiencing any of these symptoms lately?

Itchy Eyes	__	Itchy Throat	__	Hives	__
Watery Eyes	__	Cough	__	Itchy Rash	__
Red Eyes	__	Trouble Breathing	__	Non-Itchy Rash	__
Swollen Eyes	__	Wheezing	__	Other:	__________
Itchy Nose	__	Difficulty Swallowing	__		__________
Runny Nose	__	Lip Swelling	__		__________
Congested Nose	__	Face Swelling	__		__________
Sneezing	__	Eye Swelling	__		

How long have you been experiencing these symptoms? ___________________________

Current Medications: (prescription and over the counter medications)

Name of Drug	Dosage (10 mg, 2 puffs, 1 tsp, etc)	How often taken (1 x day, as needed, etc)
________________________	___________________	_______________________________
________________________	___________________	_______________________________
________________________	___________________	_______________________________
________________________	___________________	_______________________________
________________________	___________________	_______________________________
________________________	___________________	_______________________________

Allergic to any medications? ☐ No ☐ Yes (list medication AND reaction) ___________________________________

____

____

Do you or any family members suffer from any of the following:

	Patient	Family Member	Relationship to patient
Asthma	__	__	______________________________
Allergies	__	__	______________________________
Lung Disease	__	__	______________________________
Diabetes	__	__	______________________________
High Blood Pressure	__	__	______________________________
Heart Disease	__	__	______________________________
Bleeding Disorders	__	__	______________________________
Seizure Disorder	__	__	______________________________

Have you had any other medical conditions/procedures, other than the ones listed above? (Cancer, sinus surgery, immune deficiency, auto immune disease, psychiatric/mental health etc) ____

Marital Status
__ Single
__ Married
__ Widowed
__Partner

Smoker
__ Non Smoker
__ In the Past (Start Year:____ Stop Year:_____
__ Current (Start Year_____ Consumption_________)
__ Chewing Tobacco

Pets
Cats #_____
Dogs #_____
Birds #_____
Other:____________________

Occupation
Job Title or Employer:________________
__ Retired
__ Disability
__ Unemployed
__ Homemaker

Education
__ Daycare
__ Currently in the _____ grade
__Currently in college ___________

If you are here for hives and/or swelling
How long have you had the symptoms:_______________
How often do you have the symptoms: _______________
What triggers your symptoms: (CIRCLE)
Heat Cold Friction Exercise Stress Food Animals
Medications Water Not Sure Other:_____________

If you are here for Insect Allergy
When did your reaction occur: _________
What type of insect ? ___________
Symptoms that occurred after sting: (CIRCLE)
Swelling at site Lip/Tongue Swelling Hives
Trouble Breathing Loss of Consciousness
Vomiting Trouble Swallowing Other:___________
Treatment given for reaction:____________________

Would you like a flu shot today? ___ Yes ___ No

RAA Redding Allergy & Asthma Center

Patient Name: First_____________________ **Middle**_____________________ **Last**________________________

Birthdate: ______________________________________ **Sex:** ☐ Male ☐ Female **Race:**_____________________

Social Security Number: ___________________________ **(For minors, please list parent's social security number.)**

Referral Physician: _______________________________**Location:** _______________________________________

Primary Care Physician: ___________________________**Location:** ______________________________________

Your Pharmacy Name:_____________________________**Location:**____________________**(at what intersection)**

Please be aware that this office does not use an answering service after business hours. If you need emergency assistance after the office has closed, please go to your nearest emergency room.

Mailing Address: ____
Street

____
City State Zip

Phone Numbers: (Cell) ____________________________ **(Home)** __________________________________

E-mail Address: ________________________________ **(For minors, please list a parent's e-mail address.)**

Referral Source: ☐ Physician ☐ Friends/Family ☐ Website/Internet ☐ Insurance company ☐ Zoc Doc

Emergency Contact Name: ______________________________ **Phone Number:** ______________________

If patient is under 18 years old, please list names of legal guardians and contact numbers:

Legal Guardian Name: ______________________________ **Phone:** ______________________

Legal Guardian Name: ______________________________ **Phone:** ______________________

Primary Insurance: ___________________________________ **ID #**____

Primary Insurance Phone Number:____

Primary Insurance Subscriber Name: ____________________ **DOB:**_____________ **Relationship:**______________

Secondary Insurance: _________________________________ **ID#**____

Secondary Insurance Phone Number:____

Secondary Insurance Subscriber Name: __________________ **DOB:**_____________ **Relationship:**______________

Please read the following statement and sign below:

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the physician. I also authorize Redding Allergy and Asthma Center to release any information required to process my claims.

Patient/Guardian Signature: ____ **Date:**_________________________

Patient Name: ____ **Birthdate:** ___________________

Contact Phone Number: ____

MEDICAL RECORDS RELEASE

I understand that my protected health information may be requested from any healthcare provider within the past 10 years who may be involved in my health treatment, and that this information may be used to conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below, I permit Redding Allergy and Asthma Center (RAAC) to obtain any medical records (including hospital and physician progress notes; radiology and imaging reports; laboratory and pathology reports; and any additional medical data) required for my treatment at RAAC.

Patient/Guardian Signature: ____ **Date:**_________________________

Patient/Guardian Printed Name: ____

PRIVACY POLICY

Please read the following Privacy Policy and Medical Records Release statements and sign below:

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this protected health information may be used in: coordination of care with other healthcare professionals; healthcare operations such as quality assessments and physician certifications; and health insurance claims processing and reimbursement.

I am aware that I may request a copy of the Notice of Privacy Policy containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that this organization has the right to change its Notice of Privacy Policy and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Policy.

Patient/Guardian Signature: ____ **Date:**_________________________

Patient Name: ____ Birthdate: ___________________

FINANCIAL AGREEMENT

Please read the following Financial Policy and sign below:

At Redding Allergy and Asthma Center, we require patients to arrange for payment for all billed services at the time of service. This helps us reduce our administrative costs, so we can keep the cost of our services affordable. Here's how it works:

- You will be asked for a credit card or debit card when you check in
- We will store this account number in your medical record
- Your card will only be charged once the Explanation of Benefits is issued by your insurance company

We are contracted with numerous insurance companies, and will file your claim as a courtesy to you. Because every plan has different stipulations regarding payment for services received, it is your responsibility to understand your benefits. If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and your insurance company does not cover these charges, we will bill you directly. This is also our policy in the event of claim refutations, such as medical necessity or pre-existing condition denials.

Please note: you will be made aware of any outstanding balance on your account through phone calls and statements in the mail. However, after 90 days of nonpayment you will be sent to our collections agency. If you are sent to collections, there will be a $50 processing fee as well as a fee of 40% of your balance added to your account that you will be responsible for.

Please be advised that when we verify your benefits, we are dependent upon the information given to us at that time. However, you are ultimately financially responsible.

Patient/Guardian Signature: ____Date:______________

NOTICE OF BALANCE PAYMENT

Please read the following Notice of Balance Payment and initial below:

You will be required to make payment, or payment arrangements, on any outstanding balance you may have accrued prior to scheduling a follow-up appointment with us.

Patient Initials: _____________________________

NOTICE OF ALLOWABLE FEES

Please read the following Notice of Allowable Fees and initial below:

The fee ranges listed below are an estimation of the charges generally allowed by insurance companies. Please be aware that if you have not met your deductible, you may be responsible for the full amount of the charges allowed by your insurance company. *These fees are only an approximation, and they do not necessarily represent actual allowed amounts by an insurance company.*

New patient appointment: $200
Allergy skin testing: $450-900
Asthma testing/spirometry: $65-$150
Asthma testing/exhaled nitric oxide measurement: $35

Patient Initials: _____________________________

Patient Name: ____ Birthdate: ___________________

Do you have a history of asthma or chronic lung disease? □ No □ Yes

If you answered "YES", please read the NIOX Test Disclosure and sign below:

ASTHMA PATIENTS ONLY

NIOX FUNCTION TEST DISCLOSURE

At Redding Allergy and Asthma Center, we implement the **NIOX MINO® Airway Inflammatory Monitoring System** to test lung function in our patients**.** It is a brand new tool designed to better diagnose and monitor your asthma. Along with the tests we currently use to look at how successful pharmaceutical therapy has been, the NIOX MINO will be an additional measure that tells us your level of lung inflammation. The device employs an easy and non-invasive method of a simple 10 second exhalation that is completely painless and even a little fun!

Some of the benefits of this new technology are:

- The possibilities of lowering your dose of medication when appropriate
- The ability to adjust medication based on your individual needs
- Insight into your treatments efficacy
- Better prediction of asthma relapse and exacerbation
- Early identification and close monitoring or airway inflammation

If the test is performed, we will bill your insurance provider for the appropriate charge. If the charge is not covered, you may receive a bill for $25.00 to cover the medical costs of performing this sensitive measurement. If you do not wish to be charged for this test, please notify the staff prior to performing the test.

Patient/Guardian Signature: ____Date:______________

The following is a list of medications that can interfere with allergy testing. In order to ensure accurate allergy test results, do not take any of these medications for 7 days prior to having allergy testing. If you have any questions, please contact our office. Thank you!

Actifed	Brompheniramine	Dytan	Pamelor	Tacaryl
Adapin	Bupropion	Elavil	Patanase Nasal Spray	Tagamet
Advil Allergy	Carbinoxamine	Eszopiclone	Pediacare	Tandur DM
Advil PM	Cetirizine	Estrafon	Pediatan	Tavist
Ah-Chew	Chlorpheniramine	Excedrin PM	Pepcid	Sudafed Nighttime
Alavert	Chlortrimeton	Extendryl	Percocet	Theraflu
Allegra	Cimetidine	Famotidine	Periactin	Tofranil
Allerhist	Clarinex	Fexofenadine	Phenergan	Triaminic
Allertan	Claritin	Hydrocodone	Polyhistine	Trazodone
Allerx	Clemastine	Hydroxyzine	Promethazine	Triavil
Alprazolam	Clonazepam	Imipramine	Protryptiline	Trimipramine
Ambien	Clomipramine	Klonopin	Pyribenzamine	Trinalin
Amitriptyline	Codeine	Limbitrol	Quetiapine	Tylenol Allergy
Anafranil	Comtrex Sinus	Lodrane	Ranitidine	Tylenol PM
Antivert	Contac Night	Loratadine	Remeron	Unisom
Asendin	Coricidin	Lorazepam	Rescon	Valium
Astelin Nasal Spray	Cyproheptadine	Lortab	Risperidone	Vicodin
Astepro Nasal Spray	Deconamine	Ludiomil	Robitussin Cough, Cold & Allergy	Vicks
Atarax	Desipramine	Lunesta	Rondec	Vistaril
Ativan	Diazepam	Marezine	Rutuss	Vivactil
Atrohist	Dimetapp	Meclizine	Ryna	Wellbutrin
Aventyl	Diphenhydramine	Mirtazapine	Rynatan	Xanax
Axid	Doxepin	Nizatidine	Ryneze	Xyzal
Azelastine Nasal Spray	Doxylamine	Norpramin	Semprex	Zantac
BC Allergy Sinus Cold	Dramamine	Nortriptyline	Seroquel	Zolpidem
Benadryl	Durahist	Nyquil	Sinequan	Zyprexa
Biohist	Duratan	Olanzapine	Singlet	Zyrtec
Bonine	Duravent	Oleptro	Sominex	
Bromfed	Dymista Nasal Spray	Oxycodone	Surmontil	