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: _____

Birthdate: _____ **Gender:** □ Male □ Female

Social Security Number: _____

Referral Physician: _____**Location:** _____

Primary Care Physician: _____**Location:** _____

Your Pharmacy Name:_____**Location:**_____

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: _____ **(Preferred)** _____ **(Alternate)**

Email Address: _____

Referral Source: □ Physician □ Friends/Family □ Website/Internet □ Insurance company □ Advertisement

Emergency Contact Name: _____ **Phone Number:** _____

If patient is a child, please list names of legal guardians and contact numbers:

Legal Guardian Name: _____ **Phone:** _____

Legal Guardian Name: _____ **Phone:** _____

Primary Insurance: □ Aetna □ BCBS □ Cigna □ Coventry □ Humana □ Medicare □ UHC
□ Other: _____

Primary Insurance Subscriber Name: _____

Subscriber Birthdate: _____ **Relationship:** □ Spouse □ Parent/Guardian □ Other: _____

Secondary Insurance:_____

Secondary Insurance Subscriber Name: _____**Subscriber Birthdate:** _____

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:**_____

REDDING ALLERGY & ASTHMA CENTER

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:_____

REDDING ALLERGY & ASTHMA CENTER

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 remember that you, the patient, are ultimately responsible for payment on your account. If you have any questions regarding our financial policy or your account, please call our office at 404-355-0078.

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
Spirometry: $50
Exhaled nitric oxide measurement: $25

Patient Initials: _____

REDDING ALLERGY & ASTHMA CENTER

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 could interfere with skin testing and must be stopped seven days before your appointment.

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