Practice limited to Allergy, Asthma, and Immunology
Adults and Pediatrics

Patient Registration Form

WELCOME TO OUR PRACTICE!

Thank you for choosing Arizona Allergy Associates for your Allergy/Immunology needs. We are committed to building a successful physician – patient relationship with you and your family which will be established at your visit. The information below is provided to assist you with your experience at our office.

What to Bring to Your Appointments:

- Current medical and prescription insurance cards
- Current ID
- Form of payment (credit/debit card) to cover the fees payable at the time of service, including copays, unmet deductible, and co-insurance

FINANCIAL POLICY

IDENTIFICATION: It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, credit card on file, etc.) as soon as possible.

PROOF OF INSURANCE: Patients are responsible to provide the correct insurance information at each visit. If current information is not obtained at the time of service, the balance will become the patient's responsibility. If information is not received in a timely fashion or is incorrect, we may be unable to resubmit charges to the new insurance due to timely filing limitations. In this event, the balance will remain the patient's responsibility.

Your insurance is a contract between you and your insurance company. It is your responsibility to know your insurance benefits, including but not limited to, deductible, co-payment amounts, laboratory services, radiology facilities and hospitals associated with your plan. If you are covered by an insurance plan that AAA in not contracted with or participates with, or you have no insurance coverage, our charge for your care or the care of your dependents will be due at the time of service.

We are contracted with most insurance plans and will file claims and process these as required by these contracts. We will file a claim for you as a courtesy if we are not contracted with your insurance carrier/plan. We will not become involved in disputes between you and your insurance carrier. This includes, but not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary to you and/or your insurance company. You are ultimately responsible for the timely payment of your account. If your insurance company does not pay us within a reasonable time, we may look to you for a payment for services rendered. All plans are not the same and they do not cover the same services. In the event your insurance company determines a service provided was "not covered", you will be responsible for the complete charge. We will provide an estimate of charges upon request.

Patients will be requested to maintain a valid credit card on file for any balances that are not paid by your insurance. You will be requested to sign a credit card authorization form, which permits us to charge your credit card in the event you have any charges that are not covered by your insurance, charges that fall under the co-payment or deducible portion of your plan, or administrative fees that are assessed by AAA such as no-show fees. **We do not accept Cash**. Payments are accepted with Visa, MasterCard, American Express, Discover, Apple Pay, Google Pay, Samsung Pay, personal check, Cashier's check, or Money Order with a valid ID only.

REFERRAL: If you need an insurance referral from a primary care physician, make sure the referral is in our office BEFORE YOUR SCHEDULED APPOINTMENT. **Referral Fax: 480-839-1874**. If we do not have this information by the date of your visit, your appointment may need to be rescheduled.

INSURED PATIENTS: All copays must be paid at time of service. If you are unable to pay your copay at time of service, your appointment may need to be rescheduled.

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Any questions regarding bills must be directed to the billing department. Any information given from sources outside of the billing department by other staff members (front office, physicians, clinical staff, etc.) regarding the billing of services will not be honored.

SELF PAY PATIENTS: Arizona Allergy Associates requires full payment at time of service unless prior arrangements have been made with our billing department. A discount is offered if paid in full at time of visit.

NON-COVERED SERVICES: Patients are responsible for services not covered by their insurance carrier.

OUTSTANDING BALANCES/COLLECTIONS: Patient balances need to be paid in full within 60 days of their first statement. Balances unpaid after 90 days are considered delinquent and subject to debt collection. If you are unable to remit the balance within the 90 days, please call our billing department to discuss payment plan options. Failure to do so will result in your account being turned over to a third-party collection agency, and a fee of 40% of the delinquent amount will be added to your balance. If an account balance is outstanding, it must be paid in full prior to any future services.

CANCELLATION/NO SHOW POLICY: We require a 24-hour notice if you need to cancel or reschedule your appointment. If we do not receive notification within this time frame, we will assess a "no show" fee of $75.
Note: This assessment will not be charged to your insurance company, and you will be solely responsible for payment.
If discharged from our practice due to multiple no shows or any other inappropriate behavior, you will be notified in writing via Certified Mail.

BALANCES ON IMMUNOTHERAPY: Any unpaid balances including allergy extract must be paid in full prior to the renewal of your extract for the next year.

MEDICAL RECORDS/FORMS: We reserve the right to charge for copies of your patient records. You may request a copy of records annually at no cost. There is no cost to copy records for other physician offices. A charge of $25 may be assessed for any forms that need to be filled out by our providers prior to the paperwork being completed

BENEFIT ASSIGNMENT

- ➢ I hereby assign my insurance benefits to be paid directly to the physicians or, if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make the check payable to Arizona Allergy Associates and me.

- ➢ I authorize the physician to deposit checks received on the patient's account when made out to the patient.

- ➢ I authorize the physician to release any information required to process claims or required in the course of my exam and treatment.

- ➢ I hereby agree to pay my account as services are provided. If for any reason a balance is owed on my account, I agree to pay promptly upon receipt of the monthly statement.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Arizona Allergy Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information
Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights:
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information

- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Arizona Allergy Associates' Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you. Arizona Allergy Associates may dismiss a patient for reasons that include but are not limited to excessive no-shows, non-compliance with treatment recommendations, or disruptive, disrespectful, or inappropriate behavior.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.
The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information:
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting a Front Office Coordinator or the HIPAA Privacy and Security Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Arizona Allergy Associates has a "No Photo, Video or Recording" Policy
Photography, video, or audio recording of any kind is not permitted within, nor outside the premises of any Arizona Allergy Associates facility. This policy is in place to protect patient privacy, enhance confidentiality, and maintain security. With your safety and the safety of Clinic staff in mind we ask that you refrain from videotaping or taking photos, videos, or recordings of any kind with your camera, cell phone, smart phone, tablet, or any other device without prior consent and supervision of the site Manager.
Our staff, doctors and other providers are not permitted to give you permission to take photos or recordings within Clinic facilities and are authorized to enforce this policy. For additional information, please speak to an Arizona Allergy Associate Clinic Manager on-site.
If you would like to obtain copies, electronic images, or other records of your medical visits, please sign a medical record release.

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: **HIPAA Privacy and Security Officer, Arizona Allergy Associates**, **705 South Dobson Road Chandler, AZ 85224.** If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.
Effective Date:
This notice is effective on or after June 1, 2017
Arizona Allergy Associates reserves the right to modify the privacy practices outlined in the notice.

SKIN TESTING

Any testing that may be required will be discussed with the provider at the time of your appointment. We may be able to do skin testing, if indicated, but our testing protocol requires that patients not take any antihistamines for five (5) days

prior to skin testing; however, some medications may require additional avoidance. If you are taking antihistamines prescribed by your physician or if you have significant skin irritation or hives, please do not discontinue the antihistamines. Any skin testing that is required will be scheduled after you have seen a provider here.
The more common antihistamines are listed below. **This is not a complete list of all antihistamines**. Many over-the-counter medications and combination drugs contain antihistamines. If you are uncertain if the medication you are taking contains an antihistamine, please do not hesitate to call our office, or check with your primary care physician or local pharmacist.

Acrivastine/Bromfed/Dimetapp Cold and Allergy Brompheniramine	Advil PM	Alavert/Claritin Loratadine	Alka Seltzer Plus Cold
Allegra Fexofenadine	Antivert Meclizine	Astelin/Astepro Azelastine	Atarax/Vistaril Hydroxyzine
Benadryl Diphenhydramine	Chlor-Trimeton/ Deconamine/ Extendryl/Hycomine Compound Chlorpheniramine	Clarinex Desloratadine	Doxepin
Kronofed	Nyquil/ZzzQuil	Pataday/Patanol, Pazeo Olopatadine	Phenergan Promethazine
Pepcid Famotidine	Periactin Cyproheptadine	Pyrilamine	Tagamet Cimetidine
Tavist/Dayhist Clemastine	Tussionex	Tylenol with one or more of the following added to the name: Allergy, Cold, Flu, PM	Unisom
Xyzal Levocetirizine	Zaditor/Alaway Ketotifen	Zantac Ranitidine	Zyrtec Cetirizine
Any medication with "sinus", "allergy"	OTC cough & cold medications	OTC sleep medications	Any medication with "hist"

CREDIT CARD ON FILE BILLING AUTHORIZATION FAQ

Q: How does the automatic billing process work?

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A: Your credit card will be captured today and stored securely. After your insurance carrier responds and provides us your remaining balance due, we may charge the patient responsibility to your credit card. Your credit card on file will only be charged when you have a balance owing on your account or for a non-covered service.

Q: How will I know how much you are going to charge me?

A: You will receive an explanation of benefits from your insurance carrier that explains exactly, according to your health insurance coverage and benefits, how much of your healthcare bill is your responsibility and how much the insurance paid along with any contractual adjustments.

Q: What if I need to dispute my bill?

A: We will always work with you to resolve any issues and will refund you if we have made a billing error. We will only charge you the amount that we are instructed by your insurance carrier to collect from you in the same way that we normally determine how much to send you a statement for in the mail. If you disagree with how your insurance carrier processed the claim, you will need to contact their customer service department directly.

Q: Will I receive a statement or receipt for the charges automatically billed to my card?

A: Not automatically. Your insurance carrier EOB and your credit card statement will be your receipt. You can at any time contact us to have an account itemization emailed to you.

Q: What is a deductible?

A: An annual deductible is the dollar amount you must pay out of your own pocket during your plan year for medical expenses before your insurance begins to pay. For example, if the policy has a $1,000 deductible, you must pay the first $1,000 of medical expenses before your insurance will begin to pay. Your insurance company must receive a claim to process to apply balances towards your deductible. Even if you have a high deductible plan, we encourage you to have us submit the claim to your insurance so you receive a contractual adjustment, and the services can be applied towards your deductible.

Q: Is my credit card secure?

A: Yes, we do not store your sensitive credit card information in our office. Keeping your card on file, offsite, in an encrypted payment gateway enhances security because it reduces exposure at each visit.

PATIENT INFORMATION:

Name of Patient: ________________________________ **Date of Birth:** _____________ **Sex:** □Male □Female

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Marital Status: □Single □Married □Widowed □Divorced □Separated Email**:** ___________________________________

Patient's Address: ____
(STREET) (CITY) (STATE) (ZIP)

Home Phone #: ____________________ **Cell Phone #:** ____________________ **Work Phone #:** ____________________

Patient Employer: ____ **Occupation:** _______________________________

Emergency Contact: Name: ____________________Phone #: ____________________Relationship: ________________

Primary Care Physician: _______________________________________ Phone: __________________________________

Referring Physician: ____ Phone: __________________________________

Other Specialists: ____ Phone: __________________________________

PARENTAL INFORMATION: Please complete the following if patient is a Minor OR on a Parent's Insurance Plan:

Father's Name: _____________________________ **Father's Date of Birth:** ______________ **Father's SSN:** ____________

Mother's Name: ____________________________ **Mother's Date of Birth:** _____________**Mother's SSN:** ___________

What is the Parent's Marital Status: □Single □Married □Widowed □Divorced □Separated?

May we contact the other parent? □Yes □No **Parent/Guardian Email:** ______________________________________

HEALTH INSURANCE:

Primary Insurance: _______________________________

If AHCCCS, which plan? ____________________________

ID #:_____________________ **Group #:**_______________

Name of Policy Holder: ____________________________

Relationship to Patient: □ Self □ Spouse □ Parent

Gender: □ Male □ Female **DOB:** _______________

Employer: _______________________________________

Secondary Insurance: ____________________________

If AHCCCS, which plan? ___________________________

ID #:_____________________ **Group #:**______________

Name of Policy Holder: __________________________

Relationship to Patient: □ Self □ Spouse □ Parent

Gender: □ Male □ Female **DOB:** ______________

Employer: ______________________________________

Pharmacy: ______________________________Crossroads: ____________________Phone: _________________________

HIPAA Disclosure:

I understand, with this signed consent, AAA may use and disclose my/my child's health information to carry out treatment, payment, and healthcare operations. I understand as part of healthcare, AAA originates and maintains paper and/or electronic records describing my or my child's health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I have the right to review the Notice of Privacy Practices prior to signing this consent and I have been provided with a copy to read. AAA reserves the right to revise its Notice at any time and a copy can be obtained by any patient/parent by sending a request to our offices.

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I have the right to request that AAA restrict how it uses or discloses my/my child's healthcare information. However, the practice is not required to agree to the restrictions requested. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, due to the restrictions on disclosure of healthcare information and its effect on the ability to perform diagnosis and treatment, AAA will be unable to provide treatment for me/my child(ren).
It is also available in any of the offices and on the practice website at www.azallergy.com

Patient/Parent/Guardian Signature: ____ Date: ____________________

Authorization to Obtain Medication History:

I hereby authorize Arizona Allergy Associates to obtain Medication History related to the patient from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment and in order to **submit and receive Electronic Prescriptions.** I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Arizona Allergy Associates may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

□Yes, I authorize Arizona Allergy Associates to obtain Medication History and to send and receive Electronic Prescriptions.

□No, I do not authorize Arizona Allergy Associates to obtain Medication History and to send and receive Electronic Prescriptions.

I have read and understand the terms above. Any changes to patient authorizations must be provided in writing to Arizona Allergy Associates. I agree to abide by all of the stated policies.

____

Patient/Legal Guardian Signature | Name of Patient | Relationship to Patient

____

Legal Guardian Printed Name (if applicable) | Date of Birth of Patient | Date form signed

____

AAA Witness Signature | Date | AAA Witness Printed

Credit Card Authorization Form

Arizona Allergy Associates is offering a secure and convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed to and processed by your insurance carrier and the insurance portion of the claim has posted to your account, or if valid insurance information was not provided at the time of service.

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☐ **I do not authorize Arizona Allergy Associates to store and charge my credit card.**

I, ________________________, authorize Arizona Allergy Associates to capture my credit card information and securely store my credit card on file. I realize I will not receive a statement, or a receipt and my insurance EOB and credit card receipt will be my notification. I may request one from the billing office after payment has processed. ________ **(initial)**

I authorize Arizona Allergy Associates to charge my credit card on file for any balance owing on the account identified below. I agree that Arizona Allergy Associates may charge my credit card on file for any balance due when they receive a copy of the EOB or within 30 days for any other past due balance owing on my account. This authorization relates to all balances not covered by my insurance company for services provided by Arizona Allergy Associates. This could be amounts resulting from balances related to copayment, deductible, co-insurance, non-covered services, denials for no coverage/eligibility, or administrative fees such as no-show fees, but is not limited to these scenarios. ________ **(initial)**

I understand that this form is valid until I give a 30-day written notice to cancel the authorization to Arizona Allergy Associates. _________ **(initial)**

Written notice must be submitted to: Billing Office, 705 S Dobson Rd, Chandler, AZ 85224

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form.

Patient Name: ______________________________

Card Holder's Name (as shown on card): ______________________________

Credit Card: ____ Visa ____ MasterCard ____ American Express ____ Discover

Last Four Digits of Credit Card: __________

Expiration Date (mm/yy): ______________ CVV No.: ______ (3-digit Security Code)

Billing Address: ____

City: ________________________ State: _______ Zip: __________________

Phone Number: ____________________ Email: ___________________________

Cardholder Signature: ______________________________ Date: _________________

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PATIENT DISCLOSURE

If you would like to delegate another individual to have unrestricted access to your medical record and the information contained therein, please provide the information in the space provided below. This permission is also revocable with written request from you at any time.

Patient Name: ____________________________________ DOB: _________________________________

□ **I do not wish my medical information to be released to any significant other.**

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□ I request and authorize Arizona Allergy Associates to review and release my medical information to the following individuals (e.g., Spouse, Parent, Sibling, etc.)

Name: ____ Relationship: __________________ Phone # _________________

Name: ____ Relationship: __________________ Phone # _________________

Name: ____ Relationship: __________________ Phone # _________________

Name: ____ Relationship: __________________ Phone # _________________

May we leave a detailed message at home with a family member or on your voicemail? □ Yes □ No

Voicemails may be left with the following people:

Name: ____ Relationship: __________________ Phone # _________________

Name: ____ Relationship: __________________ Phone # _________________

Name: ____ Relationship: __________________ Phone # _________________

Name: ____ Relationship: __________________ Phone # _________________

Patient/Parent/Guardian Signature: ____ Date: ___________________

PLEASE NOTE: This authorization will remain in effect until it is revoked in writing.

Permission to Treat a Minor

I ____, parent of _____________________________ (DOB) _____________

do hereby give permission for the above-named child to be treated by the physicians and staff members at Arizona Allergy Associates. In my absence, this minor may be evaluated in the clinical setting (office visit) and receive allergy injections, biologic injections, and complete testing as deemed medically appropriate. In my absence, I give permission

for this child to be promptly treated for any reaction or emergency by any of the clinicians available. Additionally, protected patient health information may be shared with the proxy to facilitate informed decision making.

☐ I understand that the Responsible Party must be 18 years or older

☐ I authorize my underage child (16 or 17) to bring themselves in for treatment and they have the ability to understand the risks and benefits of treatment. I also understand that my underage child must be accompanied by a parent/ guardian for any office visits.

This authorization is valid for 1 year from the date of signing and may be revoked at any time providing written notice of revocation. I understand I cannot revoke this authorization retroactively for treatment already provided.

Name of Proxy: ____ Relationship to Minor: ____________________

Parent/Guardian Signature: ____ Date: ____________________

Health Questionnaire

Patient Name: ____ DOB: ______________________

Please list the Medical Provider who referred you to our office: ______________________________________

What is your chief complaint or primary reason for coming in today?

- ○ Nasal Allergies
- ○ Asthma/Trouble Breathing
- ○ Eczema
- ○ Rash
- ○ Eye Allergies
- ○ Possible Food Allergies
- ○ Hives
- ○ Sinus Infection

- o Postnasal Drip/Drainage
- o Cough
- o Skin Swelling
- o Other: ______________________________

PAST MEDICAL HISTORY:

Has the patient been diagnosed with one of the following conditions: Please check all that apply.

- o None
- o Seasonal Allergies
- o Asthma
- o Eczema
- o Eye Allergy
- o Contact Allergy (Latex/Jewelry/etc.)
- o Chronic Sinus Infections
- o Drug Allergy
- o Eosinophilic Esophagitis
- o Angioedema

Has the patient ever been formally diagnosed with an insect allergy that required Epinephrine and/or emergency medical services (911, ER visit, ambulance)? If so, which insect?

- o None
- o Ant
- o Bee
- o Wasp
- o Yellow Jacket/Hornet
- o Yes, but not identified

Which of the non-allergy conditions has the patient been diagnosed with: (Please check all that apply)

- o None
- o Lactose Intolerance
- o Celiac Disease
- o Food Intolerance or Sensitivity
- o Acid Reflux
- o Anxiety
- o Depression
- o Low Thyroid
- o High Thyroid
- o High Blood Pressure
- o COPD
- o Emphysema
- o Sleep Apnea
- o Heart Disease
- o Lupus
- o Rheumatoid Arthritis

Has the patient ever been allergy tested before? Circle one: YES NO

Has the patient ever been on allergy shots? Circle one: YES NO

Are the Patient's immunizations up to date?

- o Yes
- o No Immunizations
- o Incomplete
- o Delayed Schedule

Has the patient ever been hospitalized overnight for Pneumonia, RSV, Asthma, or Bronchitis? (Do not include ER and Urgent Care visits where patient was sent home same day.)

- ○ No
- ○ Pneumonia
- ○ Asthma
- ○ RSV
- ○ Bronchitis

Has the patient ever been admitted in a hospital ICU, NICU, or PICU? Please include approximate date and reason.

ICU, NICU, or PICU	Reason	Approximate Date

SURGICAL HISTORY:

Has the patient ever undergone any of the following procedures: (Please check all that apply)

- ○ None
- ○ Tonsillectomy
- ○ Adenoidectomy
- ○ Sinus Surgery
- ○ Tubes in Ears

Please list any other major surgeries the patient has undergone: (Please include Approximate Date)

- ○ NONE

Surgery:	Approximate Date:

FAMILY HISTORY: Does Patient's Mom, Dad, Brother, Sister, or Children have any of these conditions: Please check all that apply and **please note next to each condition which family member (e.g. Allergies – Mom)**

- ○ None
- ○ Allergies
- ○ Asthma
- ○ Food Allergy
- ○ Eczema
- ○ Drug Allergy
- ○ Cancer
- ○ Thyroid Issues
- ○ Eosinophilic Esophagitis
- ○ Lupus
- ○ Rheumatoid Arthritis
- ○ Crohn's Disease
- ○ Ulcerative Colitis
- ○ Angioedema

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SOCIAL HISTORY: Does the patient currently use or consume any of the following? (Please check all that apply)

- N/A
- Alcohol
- Drugs
- Cigarettes
- Packs per day _____
- How long did you smoke? _____

ENVIRONMENTAL HISTORY:

Does the patient have any of these pets living with them at home?

- None
- Dog
- Cat
- Horse
- Other:_______

Do you have or use any of the following items: (Please check all that apply)

- HEPA Filter
- Air Ionizer
- Humidifier
- Vaporizer
- Dust Mite covers for pillow or
- Feather Comforter
- Feather Pillows
- Carpet in Bedrooms
- Carpet in most of the home
- No Carpet/Very Little Carpet

FOOD ALLERGIES: Has the patient ever been officially diagnosed with one of the following food allergies and prescribed Epinephrine?

- None
- Milk
- Egg
- Peanut
- Tree Nuts
- Soy
- Wheat
- Shellfish
- Fish

CURRENT MEDICATIONS: Please list all current medications: (Please include all allergy and non-allergy medications)

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REVIEW OF SYMPTOMS (ROS): Is the patient experiencing any of these symptoms? Please check all that apply.

- Fever
- Headaches
- Chills
- Weight Gain/Loss
- Blurred Vision
- Double Vision
- Eye Pain
- Chest Pain
- Palpitations
- Shortness of Breath
- Wheezing
- Frequent Cough
- Sputum
- Abdominal Pain
- Indigestion
- Dark Stool
- Nausea/Vomiting
- Urine Retention
- Painful Urination
- Urinary Frequency
- Joint Pain
- Morning Stiffness
- Cramps
- Easy Bleeding
- Easy Bruising
- Rashes
- Tremors
- Numbness
- Dizzy Spells
- Excessive Thirst
- Too Hot/Cold
- Tired/Sluggish
- Sore Throat
- Frequent Throat Clearing
- Frequent Tonsillitis
- Itchy Throat/Hoarseness
- Cold Sores
- Sneezing
- Itching
- Sniffling
- Watery Mucus
- Nosebleed
- Stuffy Nose
- Sinus Infections
- Snoring
- Nose Surgery
- Polyps
- Post-Nasal Drip
- Broken Nose
- Loss of Smell
- None

MEDICATION INFORMATION: What medications has the patient used? (Please check all that apply)

- Zyrtec/Cetirizine
- Claritin/Loratadine
- Allegra/Fexofenadine
- Hydroxyzine
- Benadryl
- Singulair/Montelukast
- Xyzal/Levocetirizine
- Flonase/Fluticasone
- Nasacort
- Rhinocort
- Nasonex
- Qnasl
- Veramyst
- Astelin/Azelastine
- Dymista
- Atrovent/Ipratropium Bromide Nasal Spray
- ProAir
- Ventolin

- Albuterol via nebulizer
- Budesonide/Pulmicort
- Flovent
- Advair
- Qvar
- Symbicort
- Dulera
- Breo
- Arnuity
- Zaditor/Ketotifen
- Pazeo
- Visine Allergy
- Pataday
- Other: __________________

Has the patient taken any antihistamines or medications containing antihistamines within five (5) days of the appointment? Including, but not limited to the following medications: Zyrtec, Claritin, Allegra, Xyzal, Alavert, Unisom, Zantac, Pepcid, Meclizine, Tylenol PM, Cold and Sinus Medicine. Circle one: YES NO