ARIZONA ALLERGY ASSOCIATES

Practice Limited to Allergy, Asthma and Immunology
Adults and Pediatrics

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Marital Status: (please circle) S M W D Sep Name of Referring Physician: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____
Street City State Zip

Employer: _____ Work Address: _____
Company Name Street City State Zip

Spouse Name: _____ Spouse Work Phone: _____ Spouse Employer: _____

Emergency Contact Name: _____ Phone Number: _____

Name of Person Responsible for Account: _____

Are you a student attending school? ☐ Yes ☐ No Name of School: _____

If Patient is a child, or a dependent on parent's health insurance plan, please complete the following information:

Parent Name: ☐ Father _____ ☐Mother _____ Phone _____

Name of Employer & Work address (if different from above) _____

Parent Social Security # & Date of Birth: Mother: _____/_____ Father: _____/_____

PRIMARY INSURANCE: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy ID#: _____

Group #: _____ SS #: _____ Co-Pay Amt: $_____

Relationship to Patient: _____

SECONDARY INSURANCE:_____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy ID#: _____

Group #: _____ SS #: _____ Co-Pay Amt: $_____

Relationship to Patient: _____

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(1) 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 to me and Arizona Allergy Associates. (2) I also authorize the physician to deposit checks received on the patient's account, when made out to the patient. (3) I also authorize the physician to release any information required to process claims or required in the course of my exam and treatment. (4) 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 month statement. By signing this document I state that all information given is accurate and current. If my insurance denies payment, I understand that I am financially responsible for charges. (5) I authorize Arizona Allergy Associates to initiate a complaint to the insurance Commissioner for any reason on my behalf. (6) I acknowledge that I was provided with the Notice of Privacy Practices of Arizona Allergy Associates. (7) I hereby authorize AAA to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy benefit Managers for the purpose of continued treatment.

Printed Name: _____ Date of Birth: _____

PATIENT INFORMATION: THANK YOU for choosing Arizona Allergy Associates (AAA) as your allergy and immunology health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy and Cancellation/No Show Policy are important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities.

We request ALL patients complete our Patient Information Form prior to seeing the provider and **annually thereafter**. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.) It is the patient responsibility to provide the office with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We may occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the office.

FINANCIAL INFORMATION: Your insurance is a contract between you and your insurance company. As a courtesy we will file your claim for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is 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. AAA cannot bill your insurance company unless you give us current valid insurance information. If your insurance company does not pay us within a reasonable time, we will look to you for 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. This office is not responsible for disputing insurance company decisions regarding coverage. Payment is due upon receipt of a statement from our office. We expect that you know your insurance benefits, including but not limited to: deductible, co-payment amounts, laboratory services, radiology facilities and hospitals associated with your plan. It is your responsibility to notify this office when your insurance company or plan benefits change. Any costs incurred by this office because of incorrect information provided to us by you or your representative will become your responsibility. If you are covered by an insurance plan that AAA is 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

CO-PAYS: ARE DUE AT THE TIME OF SERVICE PRIOR TO SEEING THE PROVIDER. There will be a $25.00 charge added if we have to bill for the co-payment. **We do not accept Cash, American Express or Discover**. Payment is accepted with Visa, and MasterCard or personal check with valid ID only. Please take time to read our full Financial Policy and Waiver; Cancellation/No Show Policy and Patient Information Form – these are very important documents and require your understanding and signature PRIOR to you being seen. **Note**: **A fee of 40% will be added to unpaid balances that require collection and/or legal services.**

CANCELLATION/NO SHOW POLICY: In order to ensure that the quality of patient care is maintained and all patients can be accommodated, it is important that you notify our office of your intentions to cancel or change your appointment at least twenty-four hours (24) prior to your scheduled appointment by calling **(480) 897-6992**. If you have an appointment scheduled on a Monday you may leave a message over the weekend on the voice mail or use the patient portal at www.azallergy.com to notify us. If no call is received within this time period you will be considered a "no show" and a charge will be assessed at $75.00. Please take the time and consideration needed to provide the proper notification of your intent to cancel your visit with your provider. We understand that there are family emergencies and/or obligations that will require you to miss a scheduled appointment without notification, we will take these instances into account, however, we strongly encourage you to inform us within 1 business day prior to your scheduled appointment so that we can accommodate another patient in that visit slot. If you have three or more missed appointments, we reserve the right to discharge you from the practice. If discharged, you will be notified in writing via certified mail. **Note**: This assessment will not be charged to your insurance company, you will be solely responsible for payment. If you need an insurance referral from a primary care physician, make sure the referral is in our office BEFORE YOUR SCHEDULED APPOINTMENT. **Fax: 480-839-1874**. Call our office to see if you need a referral form or contact your insurance company.

A charge of $10 will be made to copy any patient records (We will, however, copy patient records one time for no charge if the records go directly to the patient). There is no cost to copy records for other physician offices. A charge of $10 will be made for any forms that need to be filled out by our providers and will be collected prior to the paperwork being completed. If forms are faxed to the practice payment will be required by credit card prior to paperwork being completed.

Printed Name: _____ Date of Birth: _____

IF YOU ARE ALREADY A PATIENT OF AAA YOU MAY NOT NEED TO FILL OUT THE HEALTH QUESTIONNAIRE DEPENDING ON WHEN YOU WERE LAST SEEN IN THE OFFICE (if you last visit was greater than 3 years ago – you will need to fill out the Health Questionnaire)

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

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.

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).

Also, from time to time in caring for our patients, it may become necessary to contact you by telephone. If you are unavailable we would like to be able to leave a detailed telephone message (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave a detailed message on your answering machine, voice mail system or with a trusted family member. It should be noted that our current privacy practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s). If you would like us to be able to leave a message for someone other than yourself, please indicate the individual by name and phone number we should use in the space below. This will remain in effect until you rescind it in writing. **This does <u>not</u> give the individual below the right to access patient medical information – it is strictly to leave a message with this designated individual. If you would like to delegate another individual to have unrestricted access to your medical record and the information contained therein – please add a note to the bottom of this page in your own handwriting and sign it. This permission is also revocable with written request from you at any time.**

Answering Machine #: _____ My Cell Phone #: _____

Spouse Name: _____ Phone Number: _____

Other (Name): _____ Phone Number: _____

☐ **I DO NOT CONSENT** to have detailed messages on my phone or answering machine or with any member of my family. (Initials _____)

☐ **REVOCATION OF PRIOR CONSENT:** I wish to rescind or stop the above authorizations.

BE SURE YOU HAVE READ AND UNDERSTAND EVERYTHING ABOVE BEFORE SIGNING THIS FORM

By signing this form you verify that you read and understand all of the above policies and procedures and will abide by them (3 pages). You also verify that you have received a copy of the Notice of Privacy Practices of this Medical Practice and been afforded the opportunity to have any questions answered.

_____	_____	_____
Signature	Name of Patient	Relationship to Patient
_____	_____	_____
Printed Name	Date of Birth of Patient	Date form Signed
_____	_____	_____
AAA Witness Signature	Date	Witness Printed Name

E-Mail Address: _____

IF YOU ARE ALREADY A PATIENT OF AAA YOU MAY NOT NEED TO FILL OUT THE HEALTH QUESTIONNAIRE DEPENDING ON WHEN YOU WERE LAST SEEN IN THE OFFICE (if you last visit was greater than 3 years ago – you will need to fill out the Health Questionnaire)

Authorization to Obtain Medication History

PATIENT NAME (printed): _____

PATIENT DOB: _____

ADDRESS: _____

By signing below, I hereby authorize Arizona Allergy Associates to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment and in order to submit and receive electronic prescriptions.

_____
Date of Authorization

_____
Patient/Legal Representative or Parent/Legal Guardian **PRINTED** Name

_____
Patient/Legal Representative or Parent/Legal Guardian **SIGNATURE**

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.

ALLERGY HEALTH QUESTIONNAIRE

IF YOU ARE ALREADY A PATIENT OF AAA YOU DO NOT NEED TO FILL OUT THE HEALTH QUESTIONNAIRE (unless your last visit was greater than 3 years ago)

Printed Name: _____ Date of Birth: _____ Occupation: _____

If Patient is child: Father Occupation: _____ Mother Occupation: _____

Referred by: _____

A. MAJOR REASON FOR REFERRAL: 1) "hay fever" 2) "sinus" 3) asthma 4) ear problems 5) bronchitis 6) eye problems 7) hives 8) eczema 9) drug allergy 10) recurrent infections 11)reaction to insects 12) "stomach" problems 13) Other: _____

B. In your own words, describe your most distressing symptoms. About how old were you when your problem(s) began and in what way(s) is your life affected?

_____

C. CURRENT MEDICINES FOR ALLERGY OR ASTHMA (Please bring prescription medicines):
List medicine(s) by name, dose or strength of drug, and number of doses taken per day: List Name; Dose; Strength; Side Effects.

_____

_____

D. MEDICATIONS USED FOR ALLERGY NOT EFFECTIVE: _____

E. CURRENT NON-ALLERGY MEDICATIONS: _____

F. PAST ALLERGY HISTORY (infancy and/or childhood): 1) Milk or other food allergy 2) eczema 3) asthma 4) other _____

G. CHILDHOOD IMMUNIZATIONS: Up-to-date or incomplete? Any unusual reactions? _____

H. REVIEW OF SYSTEMS:

CONSTITUTIONAL:	☐ Fever	☐ Headaches	☐ Chills	☐ Weight Gain/Loss	
EYES:	☐ Blurred Vision	☐ Double Vision	☐ Pain		
CARDIOVASCULAR:	☐ Chest Pain	☐ Palpitations	☐ Shortness of Breath		
RESPIRATORY:	☐ Wheezing	☐ Frequent Cough	☐ Sputum		
GASTRO:	☐ Abdominal Pain	☐ Indigestion	☐ Dark Stools	☐ Nausea/Vomiting	
GENITOURINARY:	☐ Urine Retention	☐ Painful Urination	☐ Urinary Frequency		
MUSCULOSKELETAL:	☐ Joint Pain	☐ Morning Stiffness	☐ Cramps		
SKIN:	☐ Easy Bleeding	☐ Rashes	☐ Easy Bruising		
NEUROLOGICAL:	☐ Tremors	☐ Numbness	☐ Dizzy Spells		
ENDOCRINE:	☐ Excessive Thirst	☐ Too Hot/Cold	☐ Tired/Sluggish		
MOUTH & THROAT:	☐ Sore Throat	☐ Frequent Clearing	☐ Frequent Tonsillitis	☐ Itchy/Hoarseness	☐ Cold Sores
NOSE:	☐ Sneezing	☐ Itching	☐ Sniffling	☐ Watery Mucus	☐ Nose Bleed
	☐ Stuffy Nose	☐ Sinus Infections	☐ Snoring	☐ Nose Surgery	☐ Polyps
	☐ Post-Nasal Drip	☐ Broken Nose	☐ Loss of Smell	☐ Nose/ Sinus Surgery	

I. ASTHMA: mild, moderate, severe/improving, same, severe/approximate frequency of wheezing: _____

J. BRONCHIAL INFECTIONS AS AN INFANT: Bronchiolitis Croup Bronchitis (circle any that apply)

K. HISTORY OF CONTACT ALLERGY: YES NO

L. PNEUMONIA YES NO ABNORMAL CHEST X-RAY: YES NO

M. CHOKING SPELLS: YES NO FREQUENT CHOKING and/or VOMITING: YES NO

N. POSITIVE SKIN TEST FOR TB or VALLEY FEVER YES NO CHEST PAIN: YES NO

O. SMOKING HABIT: Past, Present – Type _____ # per day _____ Are (were) your parents smokers? YES NO

P. STOMACH OR INTESTINAL PROBLEMS: Poor Appetite, Nausea, Vomiting, Diarrhea, Ulcers, Pain, Black or Bloody Bowel Movements, Heartburn

Q. ECZEMA, HIVES OR SWELLING: Aggravating factors: _____

R. OTHER SKIN PROBLEMS: _____

S. FOOD ALLERGIES: List Food and Reaction: _____

T. DRUG ALLERGIES: Aspirin, Penicillin, Sulfa, X-Ray Dyes, Local Anesthesia, Other: _____

U. INSECT ALLERGY: Type of Insect _____ Reaction _____ Year _____

V. OPERATIONS: (circle) tubes in ears, tonsillectomy and/or adenoidectomy, sinus surgery, removal of nasal polyps, nasal septum repair, chest surgery

W. CIRCLE OTHER MEDICAL PROBLEMS: 1) High Blood Pressure, 2) Heart Disease, 3) Angina, 4) Diabetes, 5) Anemia, 6) Transfusions, 7) Tuberculosis, 8) Jaundice, 9) Liver Disease, 10) Arthritis, 11) Bladder or Kidney Infections, 12) Other Kidney Disease, 13) Kidney Stones, 14) Gall Stones, 15) Cancer, 16) Fainting Spells, 17) Convulsions or Epilepsy, 18) Frequent Depression, 19) Irritable, 20) Fatigue, 21) Sleep Difficulty, 22) Prostate Trouble, 23) Thyroid Trouble, 24) Glaucoma 25) Other: _____

X. FAMILY HISTORY: Did anyone in your family ever have any of the numbered conditions? Indicate number(s) on the line to the right of the appropriate blood relation. Number of: Brothers: _____ Sisters: _____

Patient's Mother _____
Patient's Father _____
Patient's Brothers _____
Patient's Sisters _____
Patient's Maternal Grandparents _____
Patient's Maternal Aunts or Uncles _____
Patient's Paternal Grandparents _____
Patient's Paternal Aunts or Uncles _____

1. Hay fever
2. "Sinus"
3. Asthma
4. Hives or Swelling
5. Eczema
6. Food Allergy
7. Drug Allergy
8. Insect Allergy
9. Emphysema
10. Tuberculosis
11. Diabetes
12. Serious Infection
13. Death in first 2 yrs of life
14. Immunodeficiency

Y. ENVIRONMENTAL: House Apartment Condo Mobile Home (Circle One)

Animals in Home: Dog Cat Rabbit Guinea Pig Hamsters Mice/rats Birds (Type)

Animals in Bedroom: YES NO (circle one) What type: _____

BEDROOM: Feather bedding? YES NO Pillows? YES NO Down Comforter? YES NO Dust Mite Cover? YES NO

HEPA Filter YES NO (Circle One) SMOKERS IN HOME: YES NO (circle one)

CARPET IN HOME: Please list location: _____ HUMIDIFIER: YES NO

TREES AND/OR GRASSES IN NEIGHBORHOOD: _____

WORK EXPOSURE: Chemical Fumes, Large Amounts of Dust, Mold or Mildew, Smokers _____

ANY SIGNIFICANT PAST EXPOSURE TO: Chemical fumes NO YES Explain: _____

CIRCLE IF YOU HAVE A: Gas Stove Gas Furnace Kerosene Space Heater

IF PATIENT IS A CHILD, is he/she in Daycare? Pre-school? Grade School? (circle one)

Z. ALLERGY TREATMENT(s):

1) Never tested before. If tested before CIRCLE appropriate item: Negative tests: (blood or skin)

Positive to: grasses, weeds, trees, dust, animals, mold, food.

Allergy shots: _____ No _____ Yes

If yes, Dr.'s name: _____ Dates: From: _____ To: _____ How often? _____

Did it help? None Some improvement Much Improvement

Serious reactions to testing or treatment? _____ YES _____ NO

Has patient ever received Cortisone-like drugs (Prednisone, Decadron, steroids) _____ Yes _____ No Date(s) _____

Is there currently an Allergist taking care of a family member? If yes, Dr. _____

PATIENT NAME: _____ DOB: _____

DATE FORM FILLED OUT AND SIGNED: _____

SIGNATURE OF PATIENT OR PARENT: _____