



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 Primary Care 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: \_\_\_\_\_

(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](http://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)**





**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: \_\_\_\_\_

Referring Physician or Primary Care Physician \_\_\_\_\_

A. MAJOR REASON FOR REFERRAL: 1) "hayfever" 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. CURRENT NON-ALLERGY MEDICATIONS: \_\_\_\_\_

E. MEDICAL HISTORY: 1) General Health:                      Excellent                      Good                      Fair                      Poor                      (circle one)

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

I. HOSPITALIZATIONS FOR ASTHMA: (List Dates and Hospital): \_\_\_\_\_

J. ASTHMA: mild, moderate, severe/improving, same, severe/approximate frequency of wheezing: \_\_\_\_\_

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

L. HISTORY OF CONTACT ALLERGY:                      YES                      NO

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

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

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

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

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

R. ECZEMA, HIVES OR SWELLING: Aggravating factors: \_\_\_\_\_

S. OTHER SKIN PROBLEMS: \_\_\_\_\_

T. FOOD ALLERGIES: List Food and Reaction: \_\_\_\_\_

U. DRUG ALLERGIES: Aspirin, Penicillin, Sulfa, X-Ray Dyes, Local Anesthesia, Other: \_\_\_\_\_

V. INSECT ALLERGY: Type of Insect \_\_\_\_\_ Reaction \_\_\_\_\_ Year \_\_\_\_\_

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

X. 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: \_\_\_\_\_

Y. 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 _____	1. Hayfever	8. Insect Allergy
Patient's Father _____	2. "Sinus"	9. Emphysema
Patient's Brothers _____	3. Asthma	10. Tuberculosis
Patient's Sisters _____	4. Hives or Swelling	11. Diabetes
Patient's Maternal Grandparents _____	5. Eczema	12. Serious Infection
Patient's Maternal Aunts or Uncles _____	6. Food Allergy	13. Death in first 2 yrs of life
Patient's Paternal Grandparents _____	7. Drug Allergy	14. Immunodeficiency

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

Animals in Home: Dog Cat Rabbit Guinea Pig Hampsters 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)

AA. 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: \_\_\_\_\_