



**REGISTRATION & TREATMENT AUTHORIZATION  
INSURANCE & PAYMENT OBLIGATION  
PATIENT DATA:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Last First Initial Sex Birthdate Marital Status

Address: \_\_\_\_\_  
 Street City State Zip

( ) ( )  
 Home Telephone Cell email

Preferred Language Race (Optional) Ethnicity (Optional)

Is it **OK** to leave a detailed message regarding your account an/or Medical Information on:

- Home Answering Machine  Anyone answering **home** phone
- Cell Phone Message  Anyone answering **cell** phone
- No  If **NO** is it ok to leave a message to return our call  YES  NO

I authorize (Name of Individual(s)) \_\_\_\_\_ to receive or discuss information related to my diagnosis, records (medical/financial), claims or financial status.

Emergency Contact Name: \_\_\_\_\_ ( ) \_\_\_\_\_

**EMPLOYER NAME:** \_\_\_\_\_ ( ) \_\_\_\_\_  
 (If patient is under 18, please provide parent's employer) Telephone

Employer Address: \_\_\_\_\_  
 Street City

Occupation: \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_ Group No.: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Ins. I.D. Number: \_\_\_\_\_

Rel. to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Employer: \_\_\_\_\_ City, State: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ Group No.: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Ins. I.D. Number: \_\_\_\_\_

Rel. to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Employer: \_\_\_\_\_ City, State: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ Address: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

**Our office policy is to charge all patients (HMO, PPO, Self Pay) a \$50 fee for missed appointments or appointments cancelled with less than 24 hours notice.**

I Authorize Allergy and Asthma Medical Group to furnish my insurance carrier(s) with any information they request to process my medical claims. I understand that HMO/PPO claims will be submitted on my behalf by the Group only after I have notified the Group of membership and necessary referral has been obtained. I understand that HMO/PPO co-payments are due at the time of services. Charges that are not a benefit of, or not authorized by, my health plan are also my responsibility.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

**CLINICAL TRIAL:** The Allergy & Asthma Medical Group conducts clinical research trials. We would like to notify patients of studies which may be of interest to them.

\_\_\_\_\_ You have my permission to contact me.

Initial

\_\_\_\_\_ I do not wish to be contacted

Initial

## **Acknowledgement of the Notice of Privacy Practices**

**The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices.**

\_\_\_\_\_  
Signature: Patient, Legal Representative, Agent

\_\_\_\_\_  
Date

### **CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is Allergy and Asthma Medical Group's policy to require your reading and signing this consent form prior to the treatment or any other medical services.

I hereby authorize Allergy & Asthma Medical Group to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered and / or engaging in health care operations.

I understand that Allergy & Asthma Medical Group's Notice of Privacy describes in more detail the types of uses and disclosures of Health Information. I understand that I have the right to review such Notice prior to signing.

I understand that I have the right to request a restriction on the use or disclosure on my Health Information. I further understand that Allergy & Asthma Medical Group is not obligated to agree to my request. I have the right to revoke this consent, in writing.

I understand that if I choose not to sign this consent, Allergy & Asthma Medical Group may withhold medical services.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA system and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

\_\_\_\_\_  
Signature: Patient, Legal Representative, Agent

\_\_\_\_\_  
Date

Allergy & Asthma Medical Group of the Bay Area, Inc  
New Patients

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Visit Date: \_\_\_\_\_

Referred to our office by: \_\_\_\_\_ Insurance: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_

Main Reason for Visit: \_\_\_\_\_

When did Symptom start? Onset: \_\_\_\_\_ days/mos/yrs      Duration: \_\_\_\_\_ days/mos/yrs

Severity:  mild       moderate       severe       incapacitating

Frequency:  intermittent       persistent       occasional

Status (Currently):  resolved       improved       no change       worsened

Aggravated by:  Nothing

airborne chemicals

animals

cat

change in weather

cold air

dog

dust/dust mites

exercise

foods

molds

nasal decongestant spray

pollen

respiratory infections

smoke

stress

strong odors / perfume

winter

spring

summer

fall

Timing:

morning

evening

bedtime

lying down

on wakening

night worsening

other: \_\_\_\_\_

at home

at work/school

inside

outside

with URI's

with weather changes

seasonally

winter

spring

summer

fall

year round

## Other Medical History

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Allergies (nose/eyes)             | <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Hepatitis A         | <input type="checkbox"/> Osteoporosis                        |
| <input type="checkbox"/> Anemia/low red cells              | <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Hepatitis B         | <input type="checkbox"/> Peptic ulcer disease/stomach ulcers |
| <input type="checkbox"/> Angina (heart-related chest pain) | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Hepatitis C         | <input type="checkbox"/> Pneumonia                           |
| <input type="checkbox"/> Anxiety/depression                | <input type="checkbox"/> COPD/emphysema      | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Kidney disease _____                |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Multiple Sclerosis                  |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Crohn's Disease     | <input type="checkbox"/> Irritable bowel     | <input type="checkbox"/> Seizure disorder                    |
| <input type="checkbox"/> Atrial fibrillation               | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Thyroid disease _____               |
| <input type="checkbox"/> Autoimmune disease _____          | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Migraine headaches  | <input type="checkbox"/> Tuberculosis                        |
| <input type="checkbox"/> Benign prostate enlargement       | <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Heart attack        |  |
| <input type="checkbox"/> Other _____                       |  |  |  |

## Past Surgical History

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Adenoidectomy      | <input type="checkbox"/> Cholecystectomy  | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> C-section                      | <input type="checkbox"/> Prostate biop. |
| <input type="checkbox"/> Angioplasty        | <input type="checkbox"/> Colectomy        | <input type="checkbox"/> Sinus surgery         | <input type="checkbox"/> D and C (Uterus)               | <input type="checkbox"/> Prostate       |
| <input type="checkbox"/> Angioplasty +stent | <input type="checkbox"/> Colostomy        | <input type="checkbox"/> Small bowel resection | <input type="checkbox"/> Hysterectomy                   | <input type="checkbox"/> Vasectomy      |
| <input type="checkbox"/> Appendectomy       | <input type="checkbox"/> Hernia repair    | <input type="checkbox"/> Thyroidectomy         | <input type="checkbox"/> Mastectomy                     |   |
| <input type="checkbox"/> Back surgery       | <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Tonsillectomy         | <input type="checkbox"/> Fibroid removal                |   |
| <input type="checkbox"/> Coronary bypass    | <input type="checkbox"/> LASIK            | <input type="checkbox"/> Breast augmentation   | <input type="checkbox"/> Breast reduction               |   |
| <input type="checkbox"/> Carpal tunnel      | <input type="checkbox"/> Liver biopsy     | <input type="checkbox"/> Tubal ligation        | <input type="checkbox"/> Hysterectomy and ovary removal |   |
| <input type="checkbox"/> Cataract           | <input type="checkbox"/> Ear tubes        | <input type="checkbox"/> Breast biopsy         | <input type="checkbox"/> Vaginal hysterectomy           |   |
| <input type="checkbox"/> Gall bladder       | <input type="checkbox"/> Fracture repair  |  |   |   |
| <input type="checkbox"/> other _____        |   |  |   |   |

## Family History

Check if Adopted

	MOTHER	FATHER	SISTER	BROTHER	CHILDREN	OTHER RELATIVE
Allergies—nasal or eye						
Asthma						
COPD, emphysema or cystic fibrosis						
Eczema						
Food allergies						
Recurrent sinus or lung infection						
Smoker						
Other significant illnesses						

## Social History

- Tobacco use  Current  Former  Never  Unknown type \_\_\_\_\_ packs per day \_\_\_\_\_
- Years smoked \_\_\_\_\_ Ever tried to quit  yes  no yr quit \_\_\_\_\_ Longest Tobacco Free \_\_\_\_\_
- Relapse Reason \_\_\_\_\_ Passive smoke exposure  yes  no
- Current every day smoker  Smoker, current status unknown  Former smoker
- Current some day smoker  Never smoker  Unknown, if ever smoked
- Alcohol use  yes  no  former type \_\_\_\_\_ frequency \_\_\_\_\_ amount \_\_\_\_\_ last drink \_\_\_\_\_
- Caffeine user  yes  no type(s) \_\_\_\_\_ amount daily \_\_\_\_\_
- Drug Use  yes  no  former type(s) \_\_\_\_\_

**Current Allergy/Asthma Medications**

(drug name)	(strength)	(number of times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Current Medications for Other Conditions**

(drug name)	(strength)	(number of times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Homeopathic/Herbal/Complimentary/Alternative treatments: \_\_\_\_\_

Drug Allergies \_\_\_\_\_

**Other Symptom Review (circle those that you are experiencing):**

**General:**

- Chills
- Fatigue
- Fever
- Weakness
- Night Sweats
- Weight gain
- Weight loss

**Respiratory:**

- Rapid breathing
- Chronic Cough
- Cough
- Frequent URI
- Coughing up blood
- Known TB exposure
- Sharp, painful breathing
- Shortness of breath
- Coughing up sputum
- Tight throat
- Extra muscles to breathe
- Wheezing
- Other: \_\_\_\_\_

**Stomach/Intestines:**

- Abdominal pain
- Bloating
- Blood in stools
- Change in stools
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Reflux
- Vomiting
- Other: \_\_\_\_\_

**Neurological:**

- Inappropriate interaction
- Dizziness
- Extremity numbness
- Extremity weakness
- Walking Disturbances
- Headache
- Incoordination
- Lightheadedness
- Memory loss
- Seizures
- Tremors
- Sense of room spinning
- Other: \_\_\_\_\_

**Musculoskeletal:**

- Back Pain
- Bone/joint symptoms
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain
- Other: \_\_\_\_\_

**Heat/Eyes/Ears/Throat:**

- Trouble swallowing
- Ear drainage
- Ear infection
- Ear pain
- Eye discharge
- Eye pain
- Eye redness
- Hearing loss
- Hoarseness
- Itchy eyes
- Nasal congestion
- Nasal drainage
- Post nasal drip
- Runny nose
- Sinus pressure
- Sneezing
- Sore throat
- Tearing
- Visual changes
- Other: \_\_\_\_\_

**Cardiovascular:**

- Chest pain
- Pain in legs with walking
- Areas of body turn blue/purple
- Swelling
- Trouble breathing at night
- Shortness of breath when lying down
- Irregular heartbeat
- Fainting
- Other: \_\_\_\_\_

**Metabolic/Endocrine:**

- Abnormal sleep pattern
- Cold intolerance
- Goiter
- Heat intolerance
- Increased activity
- Excessive thirst
- Excessive hunger
- Other: \_\_\_\_\_

**Psychiatric:**

- Anxiety
- Depression
- Insomnia
- Other: \_\_\_\_\_

**Hematologic/Lymphatic:**

- Easy bleeding
- Easy bruising
- Swollen glands
- Other: \_\_\_\_\_

**Skin:**

- Brittle hair
- Brittle nails
- Frequent skin infections
- Hair loss
- Excessive hair growth
- Hives
- Itchiness
- Mole changes
- Rash present
- Skin lesion
- Other: \_\_\_\_\_

**Immunologic:**

- Bee sting allergies
- Contact allergy
- Environmental allergies
- Food allergies
- Seasonal allergies
- Other: \_\_\_\_\_

## Home/Work Environment

Area of residence during early life  Bay Area  Other \_\_\_\_\_

Hobbies \_\_\_\_\_

Symptoms increased at work  yes  no Explain if yes \_\_\_\_\_

### Current Residence 1

Type \_\_\_\_\_ Age of building \_\_\_\_\_

How long have you lived at your current residence? \_\_\_\_\_

Yard  Ranch  Farm  Near open fields

Smokers in home  yes  no

Self  Spouse  Father  Mother  Other \_\_\_\_\_

Type of Bed:  Boxspring  Waterbed  Foam  Crib  Allergy Covered

Down Bedding?  Pillow  Comforter  Featherbed  Blanket

Bedroom:  Carpeted  Blinds  House Plants

Books  Drapes  Stuffed animals

Type of Floors:  Carpet  Hardwood  Tile  Large Area Rug

Vacuum  Regular  HEPA  Central

Any damp, moldy areas of house?  Yes  no \_\_\_\_\_

Infestation with:  mice  rats  cockroaches  other \_\_\_\_\_

Animals in the home  yes  no

Type(s) \_\_\_\_\_ Numbers: \_\_\_\_\_

Kept Inside  yes  no

Kept in Bedroom  yes  no

### Current Residence 2

Type \_\_\_\_\_ Age of building \_\_\_\_\_

How long have you lived at your current residence? \_\_\_\_\_

Yard  Ranch  Farm  Near open fields

Smokers in home  yes  no

Self  Spouse  Father  Mother  Other \_\_\_\_\_

Type of Bed:  Boxspring  Waterbed  Foam  Crib  Allergy Covered

Down Bedding?  Pillow  Comforter  Featherbed  Blanket

Bedroom:  Carpeted  Blinds  House Plants

Books  Drapes  Stuffed animals

Type of Floors:  Carpet  Hardwood  Tile  Large Area Rug

Vacuum  Regular  HEPA  Central

Any damp, moldy areas of house?  Yes  no \_\_\_\_\_

Infestation with:  mice  rats  cockroaches  other \_\_\_\_\_

Animals in the home  yes  no

Type(s) \_\_\_\_\_ Numbers: \_\_\_\_\_

Kept Inside  yes  no

Kept in Bedroom  yes  no

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

## If you have a diagnosis of Asthma, Please complete the following questionnaire:

### If you have asthma, ages 12-Adult, please fill out the Asthma Control Test information below:

- In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?  
 All of the time  Most of the time  Some of the time  A little of the time  None of the time
- During the past **4 weeks**, how often have you had shortness of breath?  
 More than once day  Once a day  3 to 6 times a week  Once or twice a week  Not at all
- During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?  
 4 or more nights a week  2 or 3 nights a week  Once a week  Once or twice  Not at all
- During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?  
 3 or more times per day  1 or 2 times per day  2 or 3 times per week  Once a week or less  Not at all
- How would you rate your **asthma** control during the past **4 weeks**?  
 Not controlled at all  Poorly controlled  Somewhat controlled  Well controlled  Completely controlled

### If you have asthma, ages 4-11, please fill out the Asthma Control Test information below:

- How is your Asthma today?  
 Very Bad  Bad  Good  Very Good
- How much of a problem is your asthma when you run, exercise or play sports?  
 It's a Big Problem, Can't do what I want  It's a Problem, I don't like it  It's a Little Problem but it's ok  It's not a Problem
- Do you cough because of your asthma?  
 Yes, All of the time  Yes, Most of the time  Yes, Some of the time  No, None of the time
- Do you wake up during the night because of your asthma?  
 Yes, All of the time  Yes, Most of the time  Yes, Some of the time  No, None of the time
- During the **last 4 weeks**, how many days did your child have daytime asthma symptoms?  
 Not at all  1-3 days  4-10 days  11-18 days  19-24 days  Everyday
- During the **last 4 weeks**, how many days did your child wheeze during the day because of asthma?  
 Not at all  1-3 days  4-10 days  11-18 days  19-24 days  Everyday
- During the last 4 weeks, how many days did your child wake up during the night because of asthma?  
 Not at all  1-3 days  4-10 days  11-18 days  19-24 days  Everyday

**For Office Use Only:**

Form reviewed with:  patient  father  mother  other \_\_\_\_\_, M.D.