



**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: _____

Other family member seen by this practice: _____

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

- | | |
|---|---|
| <input type="checkbox"/> airborne chemicals | <input type="checkbox"/> nasal decongestant spray |
| <input type="checkbox"/> animals | <input type="checkbox"/> pollen |
| <input type="checkbox"/> cat | <input type="checkbox"/> respiratory infections |
| <input type="checkbox"/> change in weather | <input type="checkbox"/> smoke |
| <input type="checkbox"/> cold air | <input type="checkbox"/> stress |
| <input type="checkbox"/> dog | <input type="checkbox"/> strong odors / perfume |
| <input type="checkbox"/> dust/dust mites | <input type="checkbox"/> winter |
| <input type="checkbox"/> exercise | <input type="checkbox"/> spring |
| <input type="checkbox"/> foods | <input type="checkbox"/> summer |
| <input type="checkbox"/> molds | <input type="checkbox"/> fall |

Timing:

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> morning | <input type="checkbox"/> at home | <input type="checkbox"/> seasonally |
| <input type="checkbox"/> evening | <input type="checkbox"/> at work/school | <input type="checkbox"/> winter |
| <input type="checkbox"/> bedtime | <input type="checkbox"/> inside | <input type="checkbox"/> spring |
| <input type="checkbox"/> lying down | <input type="checkbox"/> outside | <input type="checkbox"/> summer |
| <input type="checkbox"/> on waking | <input type="checkbox"/> with URI's | <input type="checkbox"/> fall |
| <input type="checkbox"/> night worsening | <input type="checkbox"/> with weather changes | <input type="checkbox"/> year round |
| <input type="checkbox"/> other: _____ | | |

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.