NORTHERN ARIZONA ALLERGY GROUP LLC

NORTHERN ARIZONA ALLERGY GROUP

NEW PATIENT INFORMATION

Date:_____/_____/_____

Last Name:_____ **First:**_____ **MI:**_____ **M/F**

Date of Birth:_____/_____/_____ **SSN:**_____-_____-_____ **Phone:**_____

Race:_____ **Ethnicity:**_____ **Prefer not to answer:**_____

Address:_____
Street City State Zip

Primary Care Physician:_____ **Phone:**_____

Marital Status: S/M/D/W **How were you referred to our office?**_____

Emergency Contact:_____
Name Phone(s) Relationship

Would you like to provide the office with an advanced directive? **Y/N**

Primary Insurance Carrier:_____ ID#:_____ Eff. Date:_____

Are you the policy holder? Y/N **If no, your relationship to subscriber:**_____

Policy Holder Name:_____ **Date of Birth:**_____/_____/_____ **SSN:**_____/_____/_____

Policy Holder Address:_____
Street City State Zip

Policy Holder Phone:_____ **Type: Cell / Home/ Work**

Secondary Insurance Carrier:_____ ID#:_____ Eff. Date:_____

Are you the policy holder? Y/N **If no, relationship to subscriber:**_____

Policy Holder Name:_____ **Date of Birth:**_____/_____/_____ **SSN:**_____/_____/_____

Policy Holder Address:_____
Street City State Zip

Policy Holder Phone:_____ **Type: Cell / Home/ Work**

If my insurance company requires a referral and I do not obtain a valid referral then services are considered not-covered and I am responsible for payment. It is also my responsibility to pay any co-payment and deductible amounts required by my insurance carrier. Charges for office visits are to be paid at each visit. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claims. I also request that payment of authorized benefits be made on my behalf. I assign the benefits payable, to which I am entitled, including Medicare, private insurance and other health plans to Northern Arizona Allergy Group. This assignment is to be considered valid as an original. I understand that I am financially responsible for all charges not considered a covered benefit by said insurance. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of the account or future outstanding accounts. By signing below, I authorize Northern Arizona Allergy Group to bill my insurance company for services rendered.

_____ _____
Signed (patient over 18/parent or guardian) Date

_____
Name (please print)

I authorize your office to leave messages on my voicemail or machine or with:_____
Name Relationship

NORTHERN ARIZONA ALLERGY GROUP LLC

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NEW PATIENT QUESTIONNAIRE

Rahmat Afrasiabi Board Certified in Pediatric & Adult Allergy, Asthma, & Immunology

Name:_____Date:_____/_____/_____

DOB:_____/_____/_____Age:_____Primary Care Physician:_____

History of present illness:

1. What allergy problem(s) do you have? (please check all that apply)

Runny/stuffy nose_____Sinusitis_____Insect Allergy_____Eye or ear problems_____

Asthma_____Eczema/Rash_____Drug Allergy_____Headache_____Cough_____

Hives or Swelling_____Food Allergy_____Frequent Infections_____

Other_____

_____

The major problem you wish to discuss today:

_____

2. List all medications and over-the-counter medications you are currently using(Name& Dosage):

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____ 10)_____

What medications have you tried for your allergy problem in the past?

_____

_____

Are you allergic to any medications? If so, list drug, type of reaction and when:

_____

_____

_____

_____

_____

_____

Personal & Environmental History

1. Do you currently smoke tobacco? (How much and for how long?) _____

2. Have you ever smoked? (How much and for how long?)_____

3. How much alcohol do you drink? _____Do you use recreational drugs?_____

4. Do you have any animals in the home? (Type and how long?)_____

5. Do you have mostly wall-to-wall carpeting in your home?_____ How old is your carpet? _____

6. What type of mattress/bedding do you have? (circle) Standard Waterbed Feather

7. What is your occupation? _____

8.Are you exposed to any toxic chemicals, noxious substances at work?_____

9. How long have you lived in your current home?_____

10. How long have you lived in Northern Arizona? _____

11. Do your symptoms become better while on vacation or while living somewhere else?_____

10. What are your daily activities/hobbies?

_____

_____

Review of Systems: (Do you have any of the following? Please check)

General Gastrointestinal Kidney ___Weight loss ___Nausea/Vomiting ___Trouble starting urine ___Fevers ___Diarrhea ___

Loss of urine with cough/sneeze ___Night sweats ___Change in bowel habits ___Frequent nighttime urination ___

Loss of appetite ___Trouble swallowing ___Dry mouth ___Heartburn ___Snoring___ Blood clots___

Anemia (low blood count)___ Cardiovascular ___Bleed or bruise easily ___Dry eyes ___Chest pain ___

Swollen lymph nodes ___Change in vision ___Chest pain with exercise ___Trouble hearing ___

Calf pain with exercise Musculoskeletal ___Ringing in ears ___Ankle Swelling ___Morning joint stiffness/aching___

Painful swollen joints___ Muscle tenderness or pain ___Skin rashes ___Weakness/clumsiness ___Muscle weakness ___

Frequent skin infections ___Tingling/numbness of extremities ___Abnormal bone density ___Abnormal skin lesions___

Cold/heat intolerance ___Fearful, anxious ___Excessive bleeding ___Increased thirst ___excessive worry ___

Changes in menstrual cycle ___Frequent urination ___Trouble sleeping ___Post-menopausal___Depression___

Getting a yearly flu shot is the best way to prevent getting influenza. Influenza can be dangerous for people with allergies/asthma and other chronic diseases. We recommend a yearly flu shot for all our allergy patients who have no contraindications to this vaccine. Please ask us if you have any questions concerning the flu vaccine

Patient/Parent Signature_____Date_____

Medical Provider's Initials (indicates the form has been reviewed)_____Date_____

2. Respiratory Allergies

a. Age of onset of your allergies_____, and/or asthma_____.

b. Do you have daily symptoms?_____

c. Which seasons are your allergies or asthma worse? (circle) Spring/Summer/Fall/Winter/All Year

d. Does any particular exposure make you worse? (please check all that applies)

Weather changes___, Dampness, Fragrances/Odors___, Smoke___, Dust___, Cosmetics/Aerosols___, Mold___, Cats/Dogs/Other animals___, Grass/Mowing___, Weeds___, Trees___, Exercise___, Anger/Stress___, Coughing/Laughing___, Colds/Respiratory infections___, Cold air___, Foods/Drinks___

Other:_____

e. Do you get sinus infections (yellow/green nasal drainage, pain etc..)? _____

How often?_____ How is it usually treated?_____

f. Have you had nose or sinus surgery?(when?)_____

g. Have you ever had ear tubes or a tonsillectomy? (when?)_____

h. Have you been told by a physician that you have nasal polyps?_____

i. Do you have aspirin or NSAID induced nasal symptoms &/or wheezing?_____

If you have Asthma:

j. Do you use a spacer device for inhalers?_____ Do you use a nebulizer?_____

k. Have you required maintenance inhalers?_____

If so, which ones have you used?_____

l. Have you ever required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergies or asthma?_____ If so, how many times? _____

m. Have you ever been hospitalized for your asthma?_____

n. How many times in the past 12 months have you been to the ER with asthma?_____

o. How many puffs per week of your quick relief inhaler (albuterol) do you use?_____

p. Do you wake up at night coughing or requiring your inhaler?_____

Previous Allergy Evaluation & Treatment:

1.Name of Allergist and city:

_____

2. Were you tested for allergies by skin prick test or blood test? If so, when:

_____

3. Have you ever received Allergy Shots? If so, when and for how long?

_____

3. Insect Allergy

a. Have you had a severe allergic reaction to a stinging insect? Yes/No

b. Did it cause a large local reaction? ____ OR cause hives, itching, or swelling all over the body? ____

c. Please list all insects and types of reactions they cause:

_____

_____

_____

4. Food Allergy

a. Please list all foods and reactions they cause:

_____

_____

_____

_____

_____

_____

b. Have you had hives before? (when and for how long?) _____

c. Do you have a history or currently suffer from eczema? _____

d. Are you sensitive to latex or rubber products? (explain)_____

5. Symptoms (please check all that applies)

a. Eyes: Itch___ Swell___ Burn___ Tear___ Discharge___ Dry___

b. Ears: Itch___ Fullness___ Popping___ Decreased hearing___ Pain___ Ringing___

c. Nose: Sneeze___ Itch___ Runs___ Stuffy___ Mouth breather___ Snoring___

Yellow/Green drainage___ Decreased smell___ Decreased taste___

d. Throat: Itch___ Sore___ Post nasal drip___ Throat clearing___ Swelling___ Hoarseness___

e. Lungs: Cough___ Phlegm___ History of Asthma___ Wheezing___ Chest tightness___

Shortness of breath with exercise___ Heartburn___

f. Head: Headaches? Yes/No Migraines? Yes/No What part of head?_____ How often?_____

g. Skin: Eczema___ Hives___ Swelling___ Rashes___ Where on the body?_____

Past Medical History:

1. Medical Problems: (Please check all that apply)

High blood Pressure_____Diabetes_____Thyroid Problem_____High Cholesterol_____Heart Disease_____
Abnormal Chest X-Ray_____Sleep Apnea_____Glaucoma_____Stomach Ulcer_____Hiatal Hernia_____
Heartburn/Reflux_____Cancer_____HIV/AIDS_____Hepatitis_____Positive TB Test_____Depression_____
Arthritis_____Blood Transfusion_____Kidney Disease_____Prostate Disease_____
Other:_____

2. Please list all surgical operations and hospitalizations that you have had:_____

3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood test for your allergy or breathing troubles? (comment on results)

4. Are you up to date on all recommended vaccinations?_____
5. Do you receive yearly flu vaccines? When was last?_____
6. Have you received a pneumonia vaccine? When?_____

Family History:

1. Which of your relatives have allergies or asthma? (please circle) Mother/Father/Sister/Brother/Children
Are there any hereditary diseases or other disorders in your family?

New patient environmental survey:

- Height:_____Weight:_____
- How often does patient wash their sheets:
- How often does patient change their air filters:
- Does patient have carpet: YES or NO
- Are there pets in the home: YES or NO
- Moldy areas or water leaks: YES or NO
- History of any abnormal allergic reaction: YES or NO
- Pet allergy: YES or NO
- Food allergy: YES or NO
- Medication allergy: YES or NO
- Bee allergy: YES or NO
- Asthma: YES or NO

  If yes please answer the adjoining survey
- Reflux: YES or NO
- Vaccinations up to date: YES or NO
- History or family history of auto immune disease: YES or NO
- History or family history of thyroid disease: YES or NO
- History or family history of heart disease: YES or NO
- History or family history of allergies: YES or NO

NORTHERN ARIZONA
ALLERGY GROUP
LLC

HIPPA Compliance

I, _____(please print your name) , have read and understand the office's HIPPA compliance policy. I am aware that the office dose not disclose any of my information without my permission. I understand that before release of my medical records I will be made aware. I understand that any copies of my medical records that are not being released to another provider will require me to fill out an additional consent form.

_____ _____

Patient/Parent or Guardian Signature Date

NORTHERN ARIZONA ALLERGY GROUP

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

RECEIPT ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand and will comply with the policies and procedures explained in the NORTHERN ARIZONA ALLERGY GROUP OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS form.

_____ Date____/____/____

Signed (patient over 18/parent or guardian)

_____

Name (please print)

Thank you!
Northern Arizona Allergy Group

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

_____ Date

Signautre

I understand my rights and responsibilities as a patient/ parent or guardian.

Attention patients:

We have recently received a request from Medicare to get patient's involved in our new online patient portal. Even if you are not a Medicare patient this service is still available to you free of charge. If you are interested in using our online patient portal please provide us with your Email address. The patient portal allows you to have access to your medical records including lab orders, diagnostic imaging orders, recent medications, and chart notes from the comfort of your home. The site is secure and your information is shared with only you and only if you have provided an email address. The doctor will also be able send messages thru the patient portal letting you known of any missed appointments, upcoming appointments, office changes, Holiday hours, or nearby events which our office will be participating in. The site will require log in and review a minimum of once a month.

Thank you for your cooperation and participation in our new patient portal.

Email:_____

Patient Name:_____

Patient date of birth:_____/_____/_____

If you are not interested then please write your name and circle the reason.

I _____decline use of the patient portal due to the following reason:

I do not have an email address or Other