

PATIENT INFORMATION		
Patient #:	Gender:	Date of Birth:
Last Name:		Age:
First Name:	Initial:	Social Security #:
Address:		Home Phone:
City, State, Zip:		Work Phone:
RESPONSIBLE PARTY		
Account #	Patient Relationship to Guarantor:	
Last Name:	Gender:	Marital Status:
First Name:	Date of Birth:	
Address:		Social Security #:
City, State, Zip:		Home Phone:
Employer:	Work Phone:	
Employer Address:	City, State Zip:	
Primary Care Physician:	Telephone #:	
INSURANCE INFORMATION		
Primary Insurance:		Policy/Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:
Secondary Insurance:		Policy Subscriber:
Address:		Insured Policy ID:
City, State, Zip:		Group Number:
Plan Phone:		Date of Birth:
Effective Dates:		Patient Relationship to Subscriber:
PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION		
Parent/Legal Guardian Name:		Emergency Contact:
Address(if different than patient):		Address(if different than patient):
		Patient relationship to Contact:
Parent Home Phone:		Contact Home Phone:
Parent Work Phone:		Contact Work Phone:
MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION		
<p>I hereby authorize Arizona Asthma and Allergy Institute to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges, I hereby authorize Arizona Asthma and Allergy Institute to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and effect until revoked in writing by me.</p>		
X _____		Date: _____
Signature		

Arizona Asthma & Allergy Institute

New Patient History Form

5605 W. Eugie, Suite 200
Glendale, Arizona 85304-1200

9220 E. Mountain View, Suite 200
Scottsdale, Arizona 85258-4715

4001 E. Baseline Rd Suite 201
Gilbert, AZ 85234

13026 W. Rancho Sante Fe Blvd. Suite A-100
Avondale, AZ 85323

NAME _____ AGE _____ DATE _____

DATE OF BIRTH _____ SEX _____

PATIENT'S REGULAR DOCTOR _____ Referred by _____

WHAT PROBLEMS DO YOU WANT EVALUATED (Circle)

1. Hay fever or nasal problems
2. Eye symptoms
3. Sinus and/or Ear problems
4. Breathing difficulties- Asthma, bronchitis, cough, etc.
5. Skin problems- Hives or swelling, eczema, or other rash
6. Insect reaction (local swelling)
7. Drug reaction
8. Food reaction
9. Headaches
10. Other

WHAT ARE YOUR SYMPTOMS (Circle appropriate symptoms)

Nasal Symptoms

- how many years?
- nasal discharge- clear, yellow, green
- post nasal drip
- sneezing
- nasal itchiness
- nasal congestion
- frequent nose blowing
- loss of smell/taste
- throat itchiness
- daily, weekly, seasonal?

Sinus Symptoms

- frequent sinus infections
- facial pain and tenderness
- tooth pain
- pressure and congestion
- colored nasal discharge
- headaches

Chest Symptoms

- cough, wheeze, shortness of breath
- how long?
- daily, weekly, or monthly?
- chest tightness
- waking up at night
- how many nights per week?
- do you cough up anything? What color?
- have you tried any inhalers or albuterol?
- do you have a nebulizer or breathing machine?
- do you have a peak flow meter?
- how many severe episodes in the last year?
- have you used prednisone or oral steroids?
- have you been to the emergency room?
- have been hospitalized for the chest symptoms? When?
- do you have stomach reflux?
- do you have problems with exercise?

Eye Symptoms

- itchiness, redness, puffiness
- watery discharge
- eyelid irritation
- dark circles under eyes
- do you use eye drops?

Skin symptoms

- hives, welts, red patches, itchiness
- eczema
- areas of swelling
- how long?
- family history of swelling or eczema?
- recent infection?
- recent antibiotic use?

WHAT TRIGGERS YOUR SYMPTOMS ? (Circle) (Beside each circled item, N=nasal, C=chest)

ALLERGIES

- pollens (grass, weeds, trees) N C
- animals (cat, dog, horse) N C
- mold/mildew N C
- dust N C
- foods N C

INFECTION

- viral colds N C
- sinus infection N C

OTHER

- antibiotics N C
- aspirin N C
- chemicals N C
- insects N C
- other

IRRITANTS

- weather changes N C
- wind N C
- cold air/humidity N C
- exercise N C

IRRITANTS

- woodstove/fireplace N C
- strong odors N C
- perfumes/chemicals N C
- tobacco smoke N C

UNKNOWN

- emotions N C
- stress N C
- laughter N C
- crying N C

Patient Name _____

CIRCLE WHICH MONTHS YOU HAVE SYMPTOMS

Nose/Ears JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Sinus JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Breathing JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC
Skin JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

ENVIRONMENTAL HISTORY (Circle)

Current residence: city _____ Length at this location _____

Previous locations: _____

Resident type: House Condo Apt Mobile home

Landscaping: Desert Grass Trees Decorative gravel / rock

Neighborhood: Residential Rural Agricultural Industrial Business

Heating: Gas Electric Wood stove Other

Cooling: Air conditioning Swamp cooler Central Room only None Other

Allergen air filtration: None Small bedside Electronic HEPA

Smokers at home? N Y If yes, who: _____

Flooring: Carpet Tile Wood Linoleum Area rugs Concrete

Bedroom: Box spring mattress Waterbed Bunk bed Futon Mattress covered in plastic

Pillows: Polyester Foam Feather None

Animal Exposure: None Cat Dog Horse Rabbit Hamster Gerbil Bird

In bedroom In House Outside only Parents/Baby sitters

Work: Type of work _____ Number of work days missed over the past 12 months _____

Are your symptoms worse at work? N Y Describe _____

School: Daycare Elementary Junior High High School College

Number of school days missed over the past 12 months _____

Are your symptoms worse at school? N Y Describe _____

If daycare- is there exposure to: animals wood stoves tobacco smoke

CURRENT MEDICATIONS (List medicines taken for any reason including aspirin, blood pressure, thyroid, nose sprays, etc.)

Name of medication	Dose	How often taken	Additional medications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIOR ALLERGIC REACTIONS

Drug Reaction: Medication _____ Reaction _____
Medication _____ Reaction _____
Medication _____ Reaction _____

Insect Reaction: Insect type _____ Reaction _____
When did this occur? _____
Symptoms: tongue or throat swelling hives shortness of breath wheeze local swelling

Food Reaction: What were you eating? _____
Time from eating to onset of reaction? _____
Symptoms: tongue or throat swelling hives nausea vomiting diarrhea shortness of breath wheeze

PREVIOUS ALLERGY CARE (Circle those that apply)

- Never tested before
- Tested before: skin tests blood tests
Negative Positive Grass Weeds Trees Dust Animals Molds Foods
- Allergy shots? N Y If yes, name of doctor and locations _____
Dates _____ to _____ Degree of help: None Slight Moderate Great
- Previous sinus x-ray or CT scan?
- Previous ENT or Pulmonary evaluation?
- Previous CXR?

Patient Past Medical, Family, and Social History

Have you had any of the following	<u>Yes</u>	<u>No</u>	<u>Describe the problem when appropriate</u>
1. Abnormal chest x-ray			_____
2. Anesthesia complications			_____
3. Anxiety, depression or mental illness			_____
4. Blood problems (abnormal bleeding or anemia)			_____
5. Diabetes			_____
6. Growth removed from the colon or rectum			_____
7. Hepatitis			_____
8. High blood pressure			_____
9. High cholesterol or triglycerides			_____
10. Sexually transmitted disease			_____
11. Stroke or TIA			_____
12. Treatment for alcohol and/or drug abuse			_____
13. Tuberculosis or positive tuberculin skin test			_____
14. Cosmetic or plastic surgery			_____

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check(✓) in the following appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. (Circle) the appropriate choice when multiple choices are listed in a question:

	<u>Medical Problem</u>	<u>Surgery</u>	<u>Year(s) of Surgery</u>	<u>Describe</u>
1. Eyes (cataracts, glaucoma)			_____	_____
2. Ears, nose, sinuses, or tonsils			_____	_____
3. Thyroid or parathyroid glands			_____	_____
4. Heart valves or abnormal heart rhythm			_____	_____
5. Coronary (heart) arteries (angina)			_____	_____
6. Arteries (aorta, arms, legs)			_____	_____
7. Veins or blood clots in the veins			_____	_____
8. Lungs (pneumonia, valley fever)			_____	_____
9. Esophagus or stomach (ulcer, reflux)			_____	_____
10. Bowel or appendix			_____	_____
11. Liver or gallbladder			_____	_____
12. Pancreas			_____	_____
13. Hernia			_____	_____
14. Lymph nodes or spleen			_____	_____
15. Kidneys or bladder			_____	_____
16. Bones, joints or muscles			_____	_____
17. Back, neck or spine			_____	_____
18. Brain (headaches, seizures, depression)			_____	_____
19. Skin			_____	_____
20. Females: breasts, uterus, tubes, ovaries			_____	_____
21. Males: prostate, testes, vasectomy			_____	_____

Pediatric History (Please fill out this section if patient is <12 years old)

Pregnancy: Full term Preterm Describe _____
 Complications during pregnancy _____
 Labor and delivery: Normal Complications Describe _____
 Newborn nursery course: Normal Complications Describe _____
 Growth and development: Normal Complications Describe _____
 Immunizations up to date: Yes No
 History of RSV infection?

Patient Name _____

FAMILY MEDICAL HISTORY (Indicate any medical, allergic, or respiratory disorders)

Mother _____
Father _____
Brother/Sister _____
Grandparents _____
Other _____

SOCIAL HISTORY

Education: How many years of school have you completed? _____

Occupations: Your current employment status: Employed Retired Homemaker Student Unemployed
Employed-current occupation(s): _____
Previous Occupations/Jobs: _____
Spouses Employment _____
Parent's Employment _____

Disability: Are you disabled: No Yes _____

Abuse: Have you ever been physically, sexually, or emotionally abused? No Yes _____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used	Type/Amount/Frequency	How Long? (Years)	If stopped, when?(Years)
Tobacco	Yes No	Yes No			
Alcohol-beer wine, liquor	Yes No	Yes No			
Caffeine-coffee, tea, soda	Yes No	Yes No			
Recreational/Street drugs	Yes No	Yes No			

Marital Status: Are you currently married? No Yes In what year did this marriage occur? _____

List any previous marriages (year married and duration): _____

Current Spouse: Not applicable Alive (Name _____) Deceased

Health problems or cause of death: _____

Reviewed and annotated by: (Physician only)

Signature	Date	Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS

Form 201

Patient Name _____

Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking Yes or No for each question. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question. If yes, please explain.

- | | <u>YES</u> | <u>NO</u> | Notation |
|---|------------|-----------|----------|
| 1. Skin rash, hives, itchiness, dry skin? | | | _____ |
| 2. <u>Unhealing sores, excessive bruising or change of a mole</u> | | | _____ |
| 3. Excessive thirst or urination? | | | _____ |
| 4. Weight gain or loss, cold intolerance, or tremor? | | | _____ |
| 5. <u>Change in sexual drive or performance?</u> | | | _____ |
| 6. Significant headaches, seizures, blurred speech or difficulty moving an arm or leg? | | | _____ |
| 7. <u>Numbness or tingling of hands or feet?</u> | | | _____ |
| 8. Eye problems such as double vision, cataracts or glaucoma? | | | _____ |
| 9. Diminished hearing, dizziness, hoarseness, sinus problems or nasal polyps? | | | _____ |
| 10. <u>Do you wear dentures? (If yes: Full Upper Lower Partial)</u> | | | _____ |
| 11. Bothered with cough, shortness or breath, wheezing or asthma? | | | _____ |
| 12. Coughing up sputum or blood? | | | _____ |
| 13. <u>Exposed to anyone with tuberculosis</u> | | | _____ |
| 14. Blacked out or lost consciousness? | | | _____ |
| 15. Chest pain or pressure, rapid or irregular heart beats | | | _____ |
| 16. Awakening at night with shortness or breath? | | | _____ |
| 17. Abnormal swelling in the legs or foot? | | | _____ |
| 18. <u>Pain in the calves of your legs when you walk?</u> | | | _____ |
| 19. Difficulty with swallowing, heartburn, nausea, vomiting or stomach trouble? | | | _____ |
| 20. Problems with constipation, diarrhea, blood/changes in bowel movement? | | | _____ |
| 21. Have you had a colon or rectum x-ray? | | | _____ |
| 22. <u>Have you undergone protoscopy, sigmoidoscopy, or colonoscopy?</u> | | | _____ |
| 23. Difficulty starting your urinary stream or completely emptying your bladder? | | | _____ |
| 24. Leaking urine or blood in the urine? | | | _____ |
| 25. <u>Burning sensation or pain with urinating</u> | | | _____ |
| 26. <u>Pain, stiffness or swelling in your back, joints or muscles?</u> | | | _____ |
| 27. Fever within the last month? | | | _____ |
| 28. <u>Enlarged glands (lymph nodes)?</u> | | | _____ |
| 29. Experiencing an unusually stressful situation? | | | _____ |
| 30. Weight gain or loss of more than 10 pounds during the last 6 months? | | | _____ |
| 31. Problems falling asleep, staying asleep, sleep apnea or disruptive snoring? | | | _____ |
| 32. <u>Abnormal nipple discharge or a breast lump?</u> | | | _____ |
| 33. Have you every felt a need to cut down on your alcohol consumption? | | | _____ |
| 34. Do relatives/friends worry or complain about your alcohol consumption? | | | _____ |
| 35. <u>Have you been physically, sexually, or emotionally abused?</u> | | | _____ |
| QUESTIONS 36-43 TO BE ANSWERED BY FEMALE PATIENTS ONLY: | | | |
| 36. Have you ever had an abnormal Pap smear? Unknown | | | _____ |
| 37. Have you experienced menopause or had a hysterectomy? | | | _____ |
| 38. If no: Are you concerned about your menstrual periods? | | | _____ |
| 39. Might you be pregnant at this time? | | | _____ |
| 40. Date or onset of your last menstrual period: <u>mo:</u> <u>day:</u> <u>yr:</u> _____ | | | _____ |
| 41. Approximate date of your last Pap smear or pelvic exam: <u>mo:</u> <u>day:</u> <u>yr:</u> _____ | | | _____ |
| 42. Approximate date of your last mammogram: <u>mo:</u> <u>day:</u> <u>yr:</u> _____ | | | _____ |
| 43. Number of: Pregnancies _____ Live Births _____ Miscarriages/abortions _____ | | | _____ |

Reviewed and annotated by: (Physician only)

Signature	Date	Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Acknowledgement of Receipt of Privacy Notice
Original to be maintained in Patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Printed Patient Name

Acct#

Patient or legally authorized individual signature

Date

Relationship
(parent, legal guardian,
personal representative, etc.)

Welcome To Our Practice!

Thank you for choosing AAAI to partner in your healthcare needs. We are committed to providing you with quality and affordable health care. Below are our office and financial policies. Please take a moment to read this in its entirety. If you require additional clarification, or have questions about these policies, please contact our office and we will be happy to assist you. A copy will be provided upon request.

- **Phones.** Telephones are answered Monday thru Friday from 8:00 am to 5:00 pm.
- **Emergencies.** Our practice has full-time coverage for patient emergencies that may occur after hours. If a problem arises during a time when the office is closed, simply call the office at (602) 843-2991 and the answering service will contact the doctor on call. Your call will be returned in a timely manner. **Please note that routine prescription refills and referrals are not considered emergencies and will not be done after hours.**
- **Prescriptions.** All prescription refill requests should be called in to your pharmacy. Your pharmacy will then contact the office if authorization is needed. Your refill requests will be handled by the practice within 24 hours after your pharmacy's request is received.
- **Test Results.** Should you have any laboratory work or other diagnostic testing done through our practice, you will be notified of the results as soon as they are available. All results must first be reviewed by the provider. After review, you will be notified.
- **Records Release.** It takes our office 5 business days to process medical records requests. Medical records will be released to any physician upon your written request and authorization as a courtesy. The fee for "non-treatment" medical records release is \$0.25 per page and payment is required upon release of the medical record(s).
- **Forms Completion.** Completion of forms for insurance purposes, such as application for insurance coverage, disability, or FMLA leave, will be billed to the patient, or representative that requests completion of the forms, at a fee of \$30.
- **Telephone Consultations.** Our office charges for telephone consultations initiated by the patient or the patient's guardian. Fees are updated in conjunction with the Center for Medicare and Medicaid Services fee schedule updates.
- **Referrals/Authorizations.** Referrals/authorizations from your Primary Care Physician or Insurance Carrier approving visits to our office, diagnostic facilities, or labs can take several days to retrieve. **You are required to contact your Primary Care Physician (PCP) at least 1 week in advance to notify them of your appointment.** Failure to do so may result in your referral/authorization being denied by your PCP and/or insurance company; therefore making you responsible for any and all charges incurred during your visit.
- **Insurance and Payment Policies**
 - **Proof of Insurance. We ask that you present your insurance card to us at every visit.** If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment for all services provided.
 - Your health insurance contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. Any questions or complaints regarding your coverage should be directed to your insurance company.
 - We are contracted with most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at the time of

service. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full is required until we can verify your coverage.

- If you are uninsured please contact our Business Office at (602) 843-2991 ext. 1410 or 1420 to obtain quotes for impending services.
- **Co-Payments/Deductibles.** Your insurance company requires us to collect co-payments and/or deductibles at the time of service. Waiver of co-payments and/or deductibles may constitute fraud under state and federal law and/or the contract terms of your insurance company. Please help us in upholding the law, and complying with the contract terms of your insurance company, by paying your co-payment and/or deductible at each visit.
- **Non-covered Services.** Please be aware that some or all of the services you receive may be non-covered or not considered medically necessary by your insurer. You must pay for these services in full.
- **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claim(s) paid. Your insurance company may need you to supply certain information directly. It is your responsibility to promptly comply with their request.
- **Account Balances.**
 - Account balances are to be paid in full unless acceptable payment arrangements have been established with our billing office.
 - Payments made to satisfy account balance(s) will always be applied to oldest date(s) of service.
 - Unpaid balances over 90 days will be referred to a collection agency and may subsequently prompt discharge from this practice.
 - If you need assistance coordinating payment from your insurance company, establishing a payment plan, or have difficulty making your co-pay or deductible, please contact the Business Office at (623) 935-3000 ext. 1410 to speak with the Business Office Manager.
- **Allergy Serum.** Patients receiving allergy serum and injections are generally responsible for paying for some of their care. The exact amount is determined by your insurance plan, and will vary depending on how much of your deductible, if any, has been satisfied. It is very difficult to accurately project your individual costs in advance of final notification from your insurance plan, but we can give general guidelines as follows:
 - The serum is mixed all at one time, and generally billed out during the first visit, with subsequent fees for the professional component of administering the medication billed out at each visit. The billed charges for the "serum-only" average \$1,600 for a one-year supply; most health plans pay between \$800 and \$1,000 for this medication.
 - The average allergy injection patient will have 60 visits over a one-year period of time, and will incur billed charges for the administration that average \$25 - \$30 per visit. Most health plans pay roughly 50% of these charges, unless there is an alternate co-pay requirement for allergy injection visits.
 - If you have a high deductible health plan and have **not** satisfied the deductible limits, you could be liable for the contracted amount of the one-year supply of serum on your first visit, plus the amount for the medical administration fee, which averages \$25 - \$30 per visit. On subsequent visits you would be responsible for only the administration fees, because the serum fees will have already been paid for the full year.

- **Charge Estimates.** Patients and responsible persons may receive charge estimates for services. Please remember this is an estimate only. Final charges are based on physician orders and total services provided.
- **Pre-Registration.** When you schedule an appointment for any of our office locations you may be contacted by one of our Pre-Registration staff to obtain and/or verify your demographic and insurance information prior to your visit. Providing this information will save you time the day of your service. The Pre-Registrar will take time to explain your insurance coverage and any deductibles or co-insurance that may be due from you.
- **Dual Custody of Children.** In cases where parents have dual custody over a minor child, or where there is a legal document assigning rights to one parent, our policy is to assign financial responsibility to the parent who authorizes treatment for the child. This authorizing parent is responsible for paying the guarantor's share of the treatment costs. If you are in this situation, and there is a legal document assigning financial responsibility to another party, it is your responsibility to make payment arrangements with the other party in advance of the child's appointment, and to ensure that payment flows through you to AAAI for the treatment.
- **Missed Appointments/Cancellations.** A \$25 Missed Appointment fee will be assessed for appointments not cancelled or rescheduled with a minimum of **24 hours advance notice**. This fee will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment(s).

Thank you for understanding our policies. Please let us know if you have any questions or concerns.

I have read and understand the office policies and agree to abide by their guidelines:

Signature of Patient or Responsible Party

____/____/____
Date

Patient No-Show / Cancellation Policy

In keeping with our goal to provide each patient with the highest standard of care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. “No-shows” or last minute cancellations leave empty appointment times for other patients in need of medical care. For this reason, a fee of \$25 may be imposed for missed or cancelled appointments with less than 24 hours notice.

Please note that no-show/late cancellation fees are patient responsibility and will not be billed to your insurance company.

Thank you in advance for your consideration and for allowing us to partner in your healthcare needs.