



Allergy & Asthma Centers of the NW

PHONE (888) ASTHMA-5

AACHELP.COM

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LOCATIONS AND DIRECTIONS; PLEASE VISIT OUR WEBSITE.

Dear Valued Patient:

Thank you for coming to us for specialized assistance in diagnosing and managing your health problems.

To maximize the benefits of coming to our clinic, we ask you to prepare for it with the following:

1. Fill out and return the attached questionnaire at your scheduled appointment time. This will give you time to think about the issues that may be important for us to know, and it will allow us to make sure we consider all aspects of your health during our examination. Please fill what you can and leave the rest to us.
2. Please bring with you any relevant test results that may have been performed or requested by other physicians.
3. If a child, please make sure to bring the immunization chart with you.
4. Please be sure to bring all the medications you are currently using, or a list of names and dosages.
5. ***If applicable AND possible, please stop taking your anti-histamine (like Benadryl, Zyrtec, Claritin, Allegra, Cough Syrups, Tylenol PM, sinus pills, etc) at least five (5) days prior to your appointment.***
6. ***If you are taking anti histamines for Hives or Urticaria DO NOT stop taking them.***
7. ***Do not forget your insurance card and your co-pay (we accept cash or check).***

We look forward to seeing you in our clinic.

Allergy & Asthma Centers of the NW.

CONSENT FOR TREATMENT:

I authorize Allergy & Asthma Centers (AAC) of the NW and its personnel to provide ongoing medical care, treatment and procedures as ordered by the physicians and/or other health care providers. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

FINANCIAL AGREEMENT:

I understand and agree that I (or parent, if patient is a minor) am financially responsible for all services provided. As a courtesy, AAC will bill my insurance carrier. Regardless of outstanding insurance claims, full payment of outstanding balances is due within 90 days of service. If my account is referred to a collection agency, I agree to pay all attorney fees, court costs, filing fees, and collection costs up to 50% of amount owing may be assessed by any collection agency retained to pursue the matter. I also agree to pay interest at the rate of one and a half percent per month (eighteen percent per year).

ASSIGNMENT OF BENEFITS:

I authorize my insurance benefits to be paid directly to Allergy & Asthma Centers of the NW. I certify that all information given in applying for payment under the Social Security Act or other health insurance plan is correct and authorize verification of coverage by AAC. A photocopy of this authorization shall be as effective and valid as the original.

CONSENT TO RELEASE OF INFORMATION:

I authorize AAC to release to my insurance carrier(s), including Medicare and any other reimbursing agency, information about my identity, treatment, diagnosis, prognosis and/or services rendered (including drug and alcohol treatment, mental health treatment, diagnosis and/or treatment of HIV, AIDS, AIDS related illness or sexually transmitted disease) as permitted by State and Federal law which may be required or requested, thus releasing North West Asthma Allergy Center from any liability for furnishing such information. I understand information may be released through electronic or paper media.

NOTICE OF HEALTH INFORMATION PRACTICES:

I acknowledge that I have been provided with and /or offered a copy of the HIPPA Notice of Privacy Practices.

Signature of Patient OR Legally authorized Representative:

DATE

Name and Relationship to patient, if not signed by the patient:

DATE

IMMUNOTHERAPY AGREEMENT: (do not sign until instructed by physician)

This is an agreement from the patient or the guardian of the patient to do immunotherapy injection treatment after understanding all benefits and risks for said patient.

Signature of Patient OR Legally authorized Representative:

DATE

Name and Relationship to patient, if not signed by the patient:

DATE

**ALLERGY & ASTHMA CENTERS OF THE NORTHWEST
PEDIATRIC PATIENT QUESTIONNAIRE**

Referral information: All the information that you give is a confidential part of the patient's medical record. *However, we will send the referring physician a written report of our evaluation with at copy to you and to all other health professionals that you list as involved in the care of the patient.*

If you do NOT want us to send a letter to the referring physician, please check here _____

Patient's Name:D.O.B: / /
Phone Number: E mail Address:

Referred by Dr: Self referral:Other:
If you do NOT want us to send a copy of our office visit to your doctors check here: _____

Name of Primary Doctor:Specialty:
Street:
City: State: Zip code:
Phone: () - Fax: () -

Name Of other providers:Specialty:
Street:
City: State: Zip code:
Phone: () - Fax: () -

Pharmacy Name:
Phone: () - Fax: () -

Medical History:
Please answer all questions even if they do not seem related to the cause for referral.

Reason (s) for coming to our clinic:

OVERALL HEALTH Please answer all questions.

Has the patient grown and gained weight normally? **Yes** ___ **No**___ **Not sure**___
Has the patients lost weight recently? **Yes** ___ **No**___ **Not sure**___
Are the patient's physical activities restricted? **Yes** ___ **No**___ **Not sure**___

PREGNANCY & DELIVERY:

Was the pregnancy normal? **Yes** ___ **No**___ **Not sure**___, Was the delivery normal? **Yes** ___ **No**___ **Not sure**___
Was special care required within the first month of life? **Yes** ___ **No**___ **Not sure**___

COUGH, ASTHMA, WHEEZING

Wheezing/ difficulty breathing/ asthma? **Yes** ___ **No**___ **Not sure**___
Cough lasting more than two weeks in the last 12 months? **Yes** ___ **No**___ **Not sure**___
More than once weekly nighttime cough and wheezing? **Yes** ___ **No**___ **Not sure**___
Does the patient exercise regularly? **Yes** ___ **No**___ **Not sure**___
Does the patient wheeze or feel short of breath when exercising? **Yes** ___ **No**___ **Not sure**___
Use of asthma inhalers, or Nebulizer machine? **Yes** ___ **No**___ **Not sure**___

EYE, NOSE AND SINUS ALLERGIES

Frequent eye itching, redness, swelling of lids, or tearing? **Yes** __ **No**__ **Not sure**__
 Use of contact lenses or glasses? **Yes** __ **No**__ **Not sure**__
 Regular or frequent use of eye drops? **Yes** __ **No**__ **Not sure**__
 Frequent or persistent stuffy or runny nose? **Yes** __ **No**__ **Not sure**__
 Frequent mouth breathing? **Yes** __ **No**__ **Not sure**__
 Frequent snoring or sleep problems because of stuffy nose? **Yes** __ **No**__ **Not sure**__
 Troubles smelling? **Yes** __ **No**__ **Not sure**__
 Frequent or regular use of nasal sprays OR allergy pills? **Yes** __ **No**__ **Not sure**__
 Adenoidectomy? And/or Tonsillectomy? **Yes** __ **No**__ **Not sure**__
 Sinus surgery? **Yes** __ **No**__ **Not sure**__
 Does the patient have headaches, or sinus problems? **Yes** __ **No**__ **Not sure**__
 Sinus X-rays OR CT scan? **Yes** __ **No**__ **Not sure**__

If tests were done, please send results with this questionnaire if available

SKIN RASHES

Any persistent/recurrent skin rash lasting over 3 weeks? **Yes** __ **No**__ **Not sure**__
 Any treatment for skin problems in last 12 months **Yes** __ **No**__ **Not sure**__

FOOD, INSECT, ALLERGIES

Is there any food that causes an undesired reaction (any form)? **Yes** __ **No**__ **Not sure**__
 Has the patient had persistent diarrhea? **Yes** __ **No**__ **Not sure**__
 Is the patient presently avoiding any food? **Yes** __ **No**__ **Not sure**__
 Any intense local or more general reaction to insect stings? **Yes** __ **No**__ **Not sure**__

DRUG ALLERGIES:

Has the patient ever had an adverse reaction to any medicine? **Yes** __ **No**__ **Not sure**__
 Drug: _____, Reaction: _____
 Drug: _____, Reaction: _____
 Any reaction to transfusion of blood products? **Yes** __ **No**__ **Not Sure**__

PRIOR EVALUATIONS FOR ALLERGY:

If yes, done by Dr: _____, what time? ___/___/___ **Yes** __ **No**__ **Not sure**__
 (please try to bring results)
 Allergy shots at any age? **Yes** __ **No**__ **Not sure**__

IMMUNIZATIONS

Make sure to send a copy of the immunization record!

Are the immunizations up to date? **Yes** __ **No**__ **Not sure**__
 Did the patient receive special vaccines listed below?
 Influenza (flu) vaccine? **Yes** __ **No**__ **Not sure**__
 Pneumonia (Pneumovax or Prevnar vaccine)? **Yes** __ **No**__ **Not sure**__
 Varicella (chicken pox) vaccine **Yes** __ **No**__ **Not sure**__
 Any adverse reaction to vaccines? **Yes** __ **No**__ **Not sure**__

ENVIRONMENT

How long has the patient lived in the same dwelling? _____
 Does the house have? Carpet____, Bed room Carpet____, Central Heating/Cooling____, Window Unit____
 Are there any pets (Cat____, Dog____, Other____) in the house(s)? **Yes** __ **No**__ **Not sure**__
 Are there smokers in the home(s) of the patient? **Yes** __ **No**__ **Not sure**__
 Have any changes been made in the home to prevent allergies? **Yes** __ **No**__ **Not sure**__

INFECTIONS AND ANTIBIOTIC USE: (Please answer all question)

More than 2 ear infections in the last 12 months? **Yes** __ **No**__ **Not sure**__

Ear tube placement? **Yes** __ **No** __ **Not sure** __
 Does the patient have hearing problems? **Yes** __ **No** __ **Not sure** __
 Any sinus infections in last 12 months? **Yes** __ **No** __ **Not sure** __
 Any severe or prolonged infection at any age? **Yes** __ **No** __ **Not sure** __
 Have antibiotics been used more than two times in the last year? **Yes** __ **No** __ **Not sure** __
 Has the patient had any of the following common childhood infections?
 Bronchiolitis (RSV infection)? **Yes** __ **No** __ **Not sure** __
 Chicken pox? **Yes** __ **No** __ **Not sure** __
 Infectious mononucleosis? **Yes** __ **No** __ **Not sure** __

IMMUNITY

Has the patient's immunity been evaluated in the past? **Yes** __ **No** __ **Not sure** __

If yes, please bring copies of all results with this questionnaire.

OTHER HEALTH PROBLEMS OR CONCERNS

(If yes, please identify the problem(s) in this section)

Diabetes, endocrine (Thyroid) **Yes** __ **No** __, Hypertension and heart **Yes** __ **No** __
 Depression, and psychiatry **Yes** __ **No** __, Easy bleeding? **Yes** __ **No** __
 Enlarged lymph nodes **Yes** __ **No** __, Joint & Muscle problems **Yes** __ **No** __

Other Medical Problems Or Surgeries not listed:

_____ , _____ , _____

FAMILY HISTORY for ALLERGY AND INFECTION (ONLY):

This is very important to understand the patient's health problems!

	Age	Healthy	Allergies	Infections	Other diseases (specify)
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Sibling(s)	_____	_____	_____	_____	_____

OCCUPATIONAL HISTORY OF THE PARENTS:

Father Works as _____, since _____

Mother Works as _____, since _____

Current or previous long exposure to: Dust __, Fume __, Toxins

Are the symptoms of the child related to the parents work? **Yes** __ **No** __ **Not sure** __

CURRENT MEDICATIONS:

Please list frequently used, over the counter, herbal meds and prescribed meds:

Medication _____ Indication _____

Medication _____ Indication _____

Medication _____ Indication _____

EXPECTATION(S) FOR THIS VISIT?

Please let us know what you expect most from the visit to our clinic?

Thank you for taking the time to fill this questionnaire. It will help us to take the best care possible of the patient. Please sign and date this questionnaire.

Signature _____ Date _____

PATIENT REGISTRATION FORM

Date of Appt _____ **Time** _____ **Parent Name:** _____

Patient Information:

Last Name: _____ First Name _____ Middle _____

Reason for visit? _____

How did you hear about us? _____

Date of Birth: _____ SS# _____ Gender: Male ___ Female ___

Address: _____

City _____ State _____ Zip _____ Vancouver ___ Tigard ___ Centralia ___ Olympia ___

Home#: _____ Wk# _____ Cell# _____

E mail Address: _____

INSURANCE INFORMATION:

Note***** we must have a copy of all insurance cards in order to courtesy bill for the patient. *****

Subscriber (Insurance holder) Name: _____
Last Name First name

Relationship to Patient: _____ Subscriber DOB: _____

Primary Insurance Co: _____ #: _____

Policy ID Number: _____ Group #: _____

Employer Name: _____

SECONDARY INSURANCE

Subscriber (Insurance holder) Name: _____
Last Name First name

Relationship to Patient: _____ Subscriber DOB: _____

Insurance Name: _____

Policy ID Number: _____ Group #: _____

Employer Name: _____ #: _____

In Case Of Emergency:

Name of Relative or friend not living with you who could reach you in case of emergency:

Name: _____ Phone: _____