Allergy &
Asthma Centers of the NW

PHONE (888) ASTHMA-5 AACHELP.COM
FAX (360) 896-8881

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 NW
ADULT 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: / /

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 patient gained or lost weight recently?	**Yes** __ No__ Not sure__
Are the patient's physical activities restricted?	**Yes** __ No__ Not sure__

COUGH, ASTHMA, WHEEZING **Yes** __ No__ Not sure__
(If yes or unsure, please answer all questions in this section)

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 night time cough and wheezing?	**Yes** __ No__ Not sure__
Does the patient wheeze or feel short of breath when exercising?	**Yes** __ No__ Not sure__
Use of asthma inhalers?	**Yes** __ No__ Not sure__

EYE, NOSE AND SINUS ALLERGIES **Yes** __ No__ Not sure__

(If yes or unsure, please answer all questions in this section)

Frequent eye itching, redness, swelling of lids, or tearing? **Yes** __ No__ Not sure__
Use of contact lenses or glasses? **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?
Tonsillectomy? **Yes** __ No__ Not sure__
Sinus Infection? **Yes** __ No__ Not sure__
Sinus Surgery? **Yes** __ No__ Not sure__
Sinus X-rays/Sinus CT scan? **Yes** __ No__ Not sure__

If tests were done, please bring in or 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 **Yes** __ No__ Not sure__
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: _____
Ant reaction to transfusion of blood products? **Yes** __No __Not Sure___

PRIOR EVALUATIONS FOR ALLERGY: **Yes** __ No__ Not sure__
If yes, done by Dr: _____, what time? ___/___/___ (please try to bring results)
Allergy shots at any age**?** **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)***

Ear tube placement? **Yes** __ No__
Does the patient have hearing problems? **Yes** __ No__
Any sinus infections in last 12 months? **Yes** __ No__
Any severe or prolonged infection at any age? **Yes** __ No__
Have antibiotics been used more than two times in the last year? **Yes** __ No__
Are there other children under 10 in the household? **Yes**__ No__

IMMUNIZATIONS

MAKE SURE TO BRING/SEND A COPY OF THE IMMUNIZATION RECORD

Influenza (flu) vaccine? **Yes** __ No__ Not sure___, Pneumonia (Pneumovax)? **Yes** __ No__ Not sure__
Any adverse reaction to vaccines? **Yes** __ No__ Not sure__

OTHER HEATLH 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)	____	_____	_____	_____	_____

SOCIAL HISTORY:

Married___, Single____, Divorced____. Alcohol: None___, Social ___, Heavy drinker___

Tobacco: None___, Social ___, Regular___ (# of packs per day___, for____ years)

OCCUPATIONAL HISTORY:

Work as_____, since_____

Prior job_____, since_____

Current or previous long exposure to: Dust___, Fume___, Industrial Toxins___

Are your symptoms related to your 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 _____

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: _____