PATIENT INFORMATION RECORD

PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

GENDER: □ MALE □ FEMALE MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____ PHONE NUMBER :_____

ADDRESS: _____ APT #:_____ CITY:_____ ST:_____ ZIP:_____

EMPLOYER/SCHOOL:_____ EMAIL:_____

REFERRED BY: □ DR._____ □ GOOGLE □ YELP □ FACEBOOK □ theallergyasthma.com □ INSURANCE COMPANY

□ OTHER_____

WOULD YOU BE INTERESTED TO PARTICIPATE IN A PAID CLINICAL RESEARCH STUDY WITH - ARK CLINICAL RESEARCH □ YES □ NO

INSURANCE

DO YOU HAVE A LEGAL CASE REGARDING YOUR CONDITION? □ YES □ NO **IS YOUR CONDITION WORK RELATED? □ YES □ NO**

PRIMARY INSURANCE:_____ ID #:_____ SUBSCRIBER NAME:_____

DATE OF BIRTH: _____ RELATION TO PATIENT:_____ SOCIAL SECURITY #:_____

SECONDARY INSURANCE:_____ ID #:_____ SUBSCRIBER NAME:_____

DATE OF BIRTH: _____ RELATION TO PATIENT:_____ SOCIAL SECURITY #:_____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

MOTHERS NAME:_____ DATE OF BIRTH_____ SOCIAL SECURITY #:_____

ADDRESS: _____ APT #:_____ CITY:_____ ST:_____ ZIP:_____

HOME/CELL/WORK #:_____ EMAIL:_____

FATHERS NAME:_____ DATE OF BIRTH_____ SOCIAL SECURITY #:_____

ADDRESS: _____ APT #:_____ CITY:_____ ST:_____ ZIP:_____

HOME/CELL/WORK #:_____ EMAIL:_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP:_____

ADDRESS: _____ APT #:_____ CITY:_____ ST:_____ ZIP:_____

HOME/CELL/WORK #:_____ EMAIL:_____

ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT, ACKNOWLEDGEMENT

1. I HEREBY GIVE MY AUTHORIZATION FOR THE ASSIGNMENT AND PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO AARCMC GROUP ON BEHALF OF THE GROUP'S PHYSICIANS RENDERING SERVICES. PLEASE NOTE AARCMC IS A SPECIALIST OFFICE AND YOUR SERVICES MAY BE SUBJECT TO YOUR DEDUCTIBLE AND/OR COINSURANCE. I AM RESPONSIBLE FOR UNDERSTANDING MY INSURANCE BENEFITS. I UNDERSTAND THAT MY INSURANCE PLAN MAY NOT PAY FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED WHETHER OR NOT THEY ARE COVERED BY THE INSURANCE. IN THE EVENT OF DEFAULT, I AGREE THAT A PHOTOCOPY OF THE AGREEMENT IS AS VALID AS THE ORIGINAL DOCUMENT.
2. IF ACTING AS A GUARANTOR FOR A PATIENT OTHER THAN MYSELF, I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR AUTHORIZING AND GUARANTEEING PAYMENT FOR SERVICES RENDERED TO THE PATIENT. IF ACCOUNT GOES INTO COLLECTIONS INTEREST WILL ACCRUE.
3. BY PROVIDING MY INSURANCE INFORMATION, I AFFIRM THAT I AM CURRENTLY AN ELIGIBLE MEMBER OF THE PLAN NAMED IN THIS INFORMATION RECORD.
4. I AUTHORIZE TREATMENT FOR MYSELF AS THE PATIENT OR TREATMENT OF THE PERSON NAMED IF MINOR ABOVE BY A LICENSED AARCMC GROUP PHYSICIAN OR WHOM THE PHYSICIAN MAY DESIGNATE AS THE SERVICE PROVIDER.
5. IF I ELECT TO PARTICIPATE IN CLINICAL TRIALS, I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR PURPOSES OF CONTACT AND STUDIES BY AARCMC GROUP AND ITS CLINICAL TRIALS AFFILIATES.

SIGNATURE: _____ **DATE:** _____

PRINT NAME:_____ **RELATIONSHIP TO PATIENT:**_____

HIPAA Notice of Privacy Practices

Allergy, Asthma, & Respiratory Care Medical Center

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose you protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting of arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Sections 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may also file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of , and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____

CONSENT FOR RELEASE OF INFORMATION

You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

Please list all persons/medical groups you would like for us to release/discuss your information to:

1)_____

2)_____

3)_____

4)_____

5)_____

Patient Signature: _____ Date._____

INTAKE QUESTIONNAIRE

ALLERGY, ASTHMA & RESPIRATORY CARE MEDICAL CENTER

PLEASE PRINT CLEARLY

Name (Last) (First)	□ Male □ Female Race	Date Of Birth Age ___/___/___ ___	Date
Street Address City	State	Zip	
Home Phone #	Work Phone #	Cell Phone #	
Primary Care Physician	Referral Source	Phone #	
Occupation	Hobbies		
If married spouse's occupation	Spouse's hobbies		

IF PATIENT IS A CHILD, COMPLETE THE FOLLOWING

Father's Complete Name	Age	Occupation	Hobbies
Mother's Complete Name	Age	Occupation	Hobbies

ALCOHOL CONSUMPTION	CURRENT SMOKING HABITS
□None □Social □Regular Drinks per week _____	□Current □Never □Quit If quit, what year? _____ If current or quit, ____# packs/day, # of years smoked _____

PRESENT MEDICATIONS

Medication	Dose & Frequency	Reason	Date Started	Date Stopped

SURGERIES AND PROCEDURES or □None

Date	Procedures

HOSPITALIZATION or □None

Date	Reason	Location

CHECK OR COMPLETE THE ANSWERS THAT BEST DESCRIBE YOUR HOME ENVIRONMENT

Type of home: □ house □ apartment □ condominium □ mobile home □ dormitory

Location of home: □ seashore □ mountain □ city □ countryside □ desert

Is there obvious? □ mildew or water damage □ roaches

Indicate indoor pets you have: □ cat □ dog □ bird □ other_____

Bedroom has □ heating □ humidifier □ air purifier □ air conditioning

Type of bedroom floor covering □ carpet □ linoleum or tile □ wood □ other_____

Type of pillows you have □ feather □ dacron/synthetic □ foam rubber □ zip cover

Age of pillows in years:_____

Front & Back

PAST MEDICAL HISTORY

EARS, EYES, NOSE & THROAT	Date Symptoms started or Diagnosed	CHECK IF CURRENT	CARDIOVASCULAR	Date Symptoms started or Diagnosed	CHECK IF CURRENT
Allergies Y N ☐ Seasonal ☐ Year Round		☐	Chest pain/Angina Y N		☐
Impaired Hearing Y N		☐	Heart Attack Y N		☐
Chronic Sinusitits Y N		☐	Hypertension Y N		☐
Glasses/Contacts Y N ☐ Farsighted ☐ Nearsighted		☐	Heart Murmur Y N		☐
Glaucoma Y N		☐	Mitral Valve Prolapse Y N		☐
Cataracts Y N		☐	Phlebitis Y N		☐
			High Cholesterol Y N		☐
RESPIRATORY			**GASTROINTESTINAL**		
Asthma Y N		☐	Gastric Ulcer Y N		☐
Bronchitis Y N		☐	Duodenal Ulcer Y N		☐
Pneumonia Y N		☐	Gall bladder disease Y N		☐
COPD Y N		☐	Constipation Y N		☐
GENITOURINARY			Hemorrhoids Y N		☐
Enlarged Prostate Y N		☐	Diarrhea Y N		☐
Frequent bladder infections Y N		☐	Heartburn/Indigestion Y N		☐
Kidney Disease Y N		☐	Esophageal Stricture Y N		☐
HEMATOLOGICAL			**NEUROPSYCHIATRIC**		
Blood disorders Y N		☐	Depression Y N		☐
Anemia Y N		☐	Convulsions/Seizures Y N		☐
DERMATOLOGICAL			Stroke Y N		☐
Eczema/Atopic Dermatitis Y N		☐	Paralysis Y N		☐
Psoriasis Y N		☐	Migraines/Headaches Y N		☐
Acne Y N		☐	**ALLERGIES**		
MUSCOLOSKELETAL			Drug Allergies Y N		☐
Carpal Tunnel Syndrome Y N		☐	Food Allergies Y N		☐
Arthritis Y N		☐	**IMMUNOLOGICAL**		
Broken Bones (specify) Y N		☐	HIV Y N		☐
GYNECOLOGICAL			Hepatitis (specify) Y N		☐
Ovarian Cysts/Tumors Y N		☐	**OTHER**		
Uterine Cysts/Tumors Y N		☐	1)		
ENDOCRINE			2)		
Diabetes Y N			3)		
Thyroid Y N			4)		

FAMILY HISTORY

	MOTHER	FATHER	BROTHERS	SISTERS	CHILDREN
HAYFEVER OR NASAL SYMPTOMS	☐	☐	☐	☐	☐
SINUS	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐
CHRONIC LUNG DISEASE OR EMPHYSEMA	☐	☐	☐	☐	☐
FOOD ALLERGY	☐	☐	☐	☐	☐
HIVES OR SWELLING	☐	☐	☐	☐	☐
ECZEMA	☐	☐	☐	☐	☐

Are there grandparents, aunts or uncles with allergy problems? ☐ NO ☐ YES, please explain _____

ASTHMA/COPD HISTORY (circle one) or ☐ None

When were you first diagnosed with asthma/COPD?_____

How many hospitalizations due to asthma/COPD? _____ Most Recent: _____ How long? _____

Last use of IM/PO steroids in the last two years: _____ How many steroids burst in the last year?_____

How many ER visits? _____ Most Recent:_____ # of school/work days missed in past year? _____

When did your asthma/COPD symptoms begin? _____

In your own words, describe the most distressing symptoms you feel which are caused by your asthma/COPD:

_____

_____

ALLERGY RHINITIS HISTORY or ☐ None

When did you first have symptoms of nasal allergies? _____

Do you have ☐ runny nose ☐ sinus headaches ☐ post nasal drainage ☐ fatigue from allergies
☐ nasal congestion ☐ sinus pressure ☐ loss of smell ☐ lack of concentration from allergies

Are your allergies active during ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ Year round

Triggers of your allergies? (check all that apply)

☐ at night ☐ dogs ☐ house dust ☐ Santa Ana winds ☐ at play ☐ at work ☐ cats ☐ feathers
☐ certain foods ☐ with air conditioning ☐ with menstrual period ☐ upon awakening ☐ mowed grass

HAVE YOU EVER HAD SINUS X-RAYS OR CT? ☐ NO ☐ YES INDICATE APPROXIMATE DATE _____

WHAT WERE THE RESULTS? _____

SKIN ISSUES:

☐ NONE ☐ ECZEMA ☐ HIVES

DESCRIBE FACTORS WHICH MAKE YOUR RASH WORSE

_____

_____

CHILDHOOD HISTORY

☐ FREQUENT EAR INFECTION ☐ FREQUENT BRONCHIAL INFECTION ☐ CROUP
☐ PNEUMONIA

☐ OTHER:_____

_____

FOOD ALLERGY ☐ NO ☐ YES

PLEASE INDICATE FOOD TYPE AND ALLERGIC REACTION:

_____

_____

_____

LATEX ALLERGY ☐ NO ☐ YES

ANY REACTION TO GLOVES OR CONDOM EXPOSURE? ☐ NO ☐ YES

IF YES, PLEASE DESCRIBE IN DETAIL: _____

_____

_____

DRUG ALLERGIES or ☐ NONE

☐ ASPIRIN ☐ SULFA ☐ LOCAL ANESTHETIC
☐ PENICILLIN ☐ X-RAY DYES ☐ OTHER: _____

DESCRIBE REACTION: _____

_____

REACTIONS TO INSECTS or ☐ NONE

☐ BEE ☐ WASP ☐ YELLOW JACKET
☐ HORNET ☐ ANT ☐ OTHER: _____

DESCRIBE REACTION: _____

_____

Indicate type of allergy tests taken before ☐ none ☐ blood ☐ skin ☐ other_____

Indicate what the test were positive to ☐ pollens ☐ molds ☐ foods ☐ dust ☐ animals ☐other_____

Have you ever received cortisone-like drugs (Prednisone, Decadron, Steroids)? ☐ NO ☐ YES

If yes, dates _____ dose_____ how long_____

Have you received allergy shots? ☐ NO ☐ YES If yes, dates from _____ to _____

How helpful were the shots? ☐ minimal help ☐ reactions ☐ helpful ☐ no help

Name and location of doctor who gave you allergy shots?_____