INTERMOUNTAIN Allergy & Asthma

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The physicians and staff of Intermountain Allergy & Asthma welcome you to our practice! The following information is provided to help make your visit as comfortable as possible.

To minimize the time you must spend in our office, please complete the enclosed questionnaire and bring it with you to your appointment. If you do not complete this form at home, please arrive 30 minutes before your scheduled appointment time, as the time we have scheduled for you does not allow for completion of the questionnaire. Parental consent is necessary for medical treatment of patients under the age of 18. It is preferable to have a parent in attendance. If for some reason this is not possible, a signed consent will be required.

Please do not wear perfume, cologne, strong-smelling hair sprays, etc. to your appointment. Skin tests are usually placed on the back, so please wear clothing that may easily be removed from the waist up. ***An initial allergy evaluation may take 2-4 hours.*** If you can't keep your scheduled appointment, please call and cancel as soon as possible.

Certain medications such as antihistamines, allergy relief and hay fever medications, and over-the-counter nighttime pain relief or sleep aid medications can interfere with allergy testing. For this reason, we ask that you stop taking these medications prior to your appointment. ***If you have asthma, continue to take all of your regular asthma medications up to the time of your appointment.*** Continue antibiotics and all medications currently being taken for non-allergic conditions. Do not stop using nose sprays before your appointment. (If you have any concern about which medicines should or should not be taken, call our office.) Continue your usual diet.

MEDICINES TO STOP

- **3 days prior to allergy testing -** Antihistamines - Allergy relief, hay fever and cold medicines (including Benadryl), over-the-counter nighttime pain relief or sleep aid medications (such as Alka Seltzer PM, Excedrin PM, Nytol, Sominex, Tylenol PM, etc.)
- **4 days prior to allergy testing –** Allegra, Claritin, Zyrtec
- **5 days prior to allergy testing –** Atarax, Clarinex, Hydroxyzine, Xyzal

MEDICINES TO CONTINUE TAKING PRIOR TO ALLERGY TESTING

- Asthma medicines
- Nasal sprays
- Inhalers
- Antibiotics
- Steroid medications such as Medrol and Prednisone
- All medications currently being taken for non-allergic conditions except those mentioned above

BRING WITH YOU TO YOUR APPOINTMENT

- **Referral** (if required by your insurance)
- **Insurance Card**
- **Photo Identification** (*If your photo identification does not include your current address, please bring a Utility Bill or other correspondence showing current address.*)
- **Co-payment** (A co-payment or 20% of your billed charge will be due at time of service.) There will be a service charge of $20 for all co-payments not paid at time of service. If you have any questions regarding your insurance coverage, contact your insurance company before your appointment. For non-insured (self-pay), please contact our billing department to make arrangements.

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COMPLETING YOUR PAPERWORK *PRIOR TO YOUR ARRIVAL* WILL ALLOW YOU TO BE SEEN PROMPTLY.
ALL PAGES OF THIS QUESTIONNAIRE MUST BE COMPLETED BEFORE THE DOCTOR CAN SEE YOU.

PATIENT INFORMATION

Date_____

Patient's full legal name_____
First Middle Last

What do you like to be called? _____ Sex_____Age_____ Date of Birth _____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____Occupation_____

Emergency Contact Name_____Phone #_____Relationship to patient_____

Personal Physician_____Address_____

Referring Physician_____Address_____

How did you hear about us?_____

Please list other household family members being seen at Intermountain Allergy Clinic _____

_____By which physician_____

RESPONSIBLE PARTY INFORMATION

Name_____Date of Birth_____Sex_____Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Employer_____Work Phone_____Home Phone_____Cell phone_____

SPOUSE INFORMATION

Spouse_____ Employer_____

Spouse work phone_____ Spouse home phone_____ Cell phone_____

INSURANCE INFORMATION

1st Insurance _____

Subscriber _____

Social Security # _____

ID#_____

Subscriber Birthdate_____ Group#_____

Subscriber Address_____

Relationship to Patient_____

2nd Insurance _____

Subscriber _____

Social Security # _____

ID#_____

Subscriber Birthdate_____Group#_____

Subscriber Address _____

Relationship to Patient _____

I authorize and request a Summary Report of this visit be sent to:

☐ Referring Physician ☐ Personal Physician ☐ None

_____ _____
Signature (Patient or Responsible Party) Print Name

Describe patient's typical symptoms: _____

_____

_____

SYMPTOMS (Circle all that apply)

Chest	Nose	Eyes	Throat	Skin	Ears
asthma	hay fever	itching	itching	itching	itching
cough	congestion	tearing	hoarseness	hives	blockage
wheeze	sneezing	swelling	voice loss	eczema	discharge
frequent infections	running	redness	frequent infections	infections	frequent infections
tightness	bleeding	styes	postnasal drip	swelling	hearing loss
shortness of breath	polyps	mattering	soreness		earaches
excess mucus	loss of smell		bad breath		
congestion	sinus infections		dryness		

SYMPTOMS: (circle) Year-round Seasonal Worst Month _____ Best Month_____

When do symptoms occur? (circle) Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Which of the following appear to cause the allergy or asthma symptoms? (check)

POLLEN: trees_____ grass_____ weeds_____

ANIMAL HAIR DANDER: cats_____ dogs_____ horse_____ other furry pets or birds_____

ODORS: Christmas trees_____ detergents_____ soaps_____ hair sprays_____ paint fumes_____

tobacco smoke_____ cosmetics and perfume_____

OTHERS: temperature change_____ air conditioning_____ exercise_____ excitement_____ fatigue_____

spicy food_____ house dust_____ nighttime_____ rubber products_____ infections (colds)_____

stress_____ laughing_____ menses (periods)_____ dampness_____ aspirin_____ windy days_____

WORK EXPOSURES: (fumes? odors?) Include names of chemicals _____

How much school or work has been missed in the past year because of allergies or Asthma?_____

Has a change in locale affected your symptoms? _____ If yes, how? _____

_____

PREVIOUS ALLERGY STUDIES:

Have skin tests been done before? _____ Have allergy blood tests been done? _____

Doctor _____ Date _____

Results _____ Allergy shots? _____ When? _____

When was the last chest x-ray? _____ Sinus x-ray? _____

MEDICATIONS: List <u>every</u> medication now being used (including non-allergy, non-asthma medications:

Drug	Frequency	Drug	Frequency
_____		_____	
_____		_____	
_____		_____	
_____		_____	

What medications have been helpful for asthma or allergies in the past? _____

_____

Has patient used Cortisone, Prednisone, Kenalog, Decadron, or other steroids? (list): _____

_____

MEDICATION ALLERGY: (aspirin, antibiotics, pain medicine, etc.) List drugs, the reactions they cause and dates reactions occurred: _____

_____

INSECT STING ALLERGY: List specific insect and type of reaction. _____

_____

FOOD ALLERGY: List specific foods and describe reaction. _____

_____

ENVIRONMENTAL CONDITIONS:

Hobbies: _____ Occupation: _____

Age of house _____ Type of construction _____ Years at present address _____

Heating and Air System: (check)

a. Gas_____ Oil_____ Electric_____ Coal_____ Other_____

b. Air conditioning? Yes _____ No _____ Type _____

c. Air filtering system? Central _____ Room _____ None _____

d. Humidifiers? Central_____ Room_____ None_____

f. Fireplace? Gas_____ Wood_____ None_____

(Please see next page)

Are there feather pillows? _____ (If yes, list where) _____

Is the basement wet, or do you see or smell mildew in the house? Yes_____ No_____

Which pets do you own? (check) dog_____ cat_____ bird_____ other _____

Are there farm animals near your home? _____ What kind? _____

Neighborhood contains: (name type if known)

Trees _____ Fields _____ Farms _____

HEALTH HABITS:

a. Smoke tobacco? Yes_____ No_____ Daily amount _____ For how many years?_____

b. Do others smoke in the home? Yes_____ No_____

MEDICAL HISTORY (check all that apply):

Has patient ever had: Tuberculosis or a positive TB Skin Test____ Ulcers____ Diabetes____ High Blood Pressure____

Glaucoma____ Heart Disease____ Cataracts____ Cancer ____ Emphysema ____ Nasal Polyps____ Chicken Pox____

Contact Lens Wearer_____ Heartburn_____ Urinary Retention_____ Other Diseases_____

_____

HOSPITALIZATIONS, OPERATIONS, AND EMERGENCY ROOM VISITS:

Date	Reason
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: If you know of allergies in any of your relatives, place check marks in the table below to show which relatives were affected by the conditions listed.

	Sisters/Brothers	Mother	Father	Children
Hay Fever or other Nasal Allergy	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Eczema	_____	_____	_____	_____
Hives	_____	_____	_____	_____

Is there a family history of any other disease or condition? List: _____

_____

INTERMOUNTAIN Allergy & Asthma

FINANCIAL CONSENT AND CONSENT TO TREATMENT

We are dedicated to providing the best possible medical care and service to you. We regard a complete explanation of our financial policy as an essential element of your care and treatment.

We are preferred providers for many insurance companies and have agreed to accept assignment of benefits upon payment of your co-pay. Co-payment or 20% of billed charge is due at the time of service. An additional service charge of $20.00 will be assessed if your co-payment is not made at the time of service.

Being a preferred provider for your insurance plan *does not guarantee* the services we provide will be covered by your insurance provider. All health plans are not the same and do not cover the same services. It is not possible for us to know the terms of hundreds of different insurance plans and the specifics of such contractual agreements. Your insurance is a contract between you and your insurance company. It is your responsibility to know and comply with the terms of your insurance contract. In the event your health plan determines a service to be "not covered," or if payment is denied due to your failure to comply with the terms of your insurance (i.e., no referral, pre-existing condition, etc.), you accept responsibility for the complete charge. **Call your health plan if you have any questions regarding your coverage.**

For all services rendered to minor patients we will look to the adult accompanying the patient and the custodial guardian for payment.

You are responsible for all collection costs incurred as a result of non-payment.

I have read and understand the Financial Consent and Consent to Treatment policy of Intermountain Allergy & Asthma and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time.

I further authorize the release of any medical information necessary to process my medical claims as well as payment of medical benefits to Intermountain Allergy & Asthma.

_____ _____

Signature Date

_____ _____

Print Name Relationship to Patient