ALLERGY AND ASTHMA CARE, P.A.

12000 ELM CREEK BLVD. #200
MAPLE GROVE, MN 55369
TEL (763) 420-1010
FAX (763) 420-3710

DATE: _______________

LEGAL NAME: ____
Last First Middle Initial

ADDRESS: ____
Street City State Zip Code

DATE OF BIRTH:	AGE:	GENDER: M ( ) F ( )	MARITAL STATUS S ( ) M ( ) SEP ( ) D ( )
HOME PHONE:	WORK PHONE:		OTHER/PAGER/CELL PHONE:
SS #:	OCCUPATION:		
PATIENT'S EMPLOYER:	BUSINESS ADDRESS:		
IS THIS VISIT WORKERS' COMPENSATION RELATED? Y ( ) N ( ) If applicable, please list Claim #			

REFERRED BY: ____CLINIC NAME: ____

PRIMARY CARE PHYSICIAN: ____________________________CLINIC NAME: ____

PHARMACY NAME/PHONE #____

IN CASE OF EMERGENCY, NOTIFY (list name & number):		
PRIMARY INSURANCE COMPANY:	PRIMARY INSURANCE COMPANY ADDRESS:	
CERTIFICATE OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	RELATIONSHIP TO PATIENT:	
POLICY HOLDER EMPLOYER:	POLICY HOLDER DOB:	
SECONDARY INSURANCE COMPANY (N/A)	SECONDARY INSURANCE COMPANY ADDRESS	
CERTIFICATE OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	POLICY HOLDER DOB:	RELATIONSHIP TO PATIENT:

***IF PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION:**

LIST NAME OF RESPONSIBLE PARTY FOR PAYMENT:	LIST RELATIONSHIP TO PATIENT:	
LIST ADDRESS OF RESPONSIBLE PARTY FOR PAYMENT:	LIST PHONE # OF RESPONSIBLE PARTY FOR PAYMENT:	
MOTHER'S NAME:	DOB:	SS #:
HOME ADDRESS:	HOME PHONE:	WORK PHONE:
FATHER'S NAME:	DOB:	SS #:
HOME ADDRESS:	HOME PHONE:	WORK PHONE:

*** PLEASE READ AND SIGN THIS SHEET AND RETURN WITH YOUR INSURANCE CARD TO THE RECEPTIONIST**

CO-PAYMENTS: Co-payments are due at the time of service.

FINANCIAL ARRANGEMENTS: We would appreciate your payment at the time of service. However, we understand that there may be circumstances in which you will want to make payment arrangements with our business office.

REFERRALS: If your insurance requires a referral, please obtain this referral prior to receiving care at Allergy And Asthma Care, P.A. by calling your primary physician or health plan. This will ensure your eligibility for maximum coverage by your plan. Information regarding referrals may be included on your identification card.

Please present current insurance information at the time of service. Please remember that you are ultimately responsible for any balance that your insurance plan does not cover. We cannot guarantee the amounts of coverage offered by your insurance carrier, as each policy is different.

CREDIT POLICY AND PATIENT RESPONSIBILITY: It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. It is your responsibility to know your insurance coverage. In the event your account becomes past due and is referred to an outside agency, you will be responsible for the collection costs along with any reasonable attorney fees.

A **FINANCE CHARGE** of 1.5% per month, 18% per year, may be imposed on any balance over 90 days old. We would be happy to assist you and your family in any way we can. Should you encounter any difficulties, please notify us as soon as possible to avoid any misunderstanding regarding your account.

To the best of my knowledge, I have completed the patient portion of this form, and I have read and understand my financial obligation and patient responsibility.

Signature of Insured______________________________________ **Date**_______________________

Responsible Party (if minor)_______________________________ **Date**_______________________

PAYMENT AUTHORIZATION/RELEASE OF RECORDS

I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO ALLERGY AND ASTHMA CARE, P.A.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS AS NECESSARY TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN OR ANOTHER PARTY OF MY DESIGNATION FROM ALLERGY AND ASTHMA CARE, P.A.
A signature must be on file in order to release your medical records to an insurance company or physician. Per state law, this authorization automatically expires in 12 months at which point we may find it necessary to have you complete another form.

Signature of Insured ______________________________________ **Date**_______________________

Responsible party (if minor) _______________________________**Date**_______________________

AUTHORIZATION TO SPEAK TO SPOUSE/RELATIVE/FRIEND

If I am not available to discuss my bill or medical care, I authorize the following individual :

____ ___________________ ____________

Name **Relationship** **Date**

Updated 5/14/09

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Richard J. Morris, M.D. **Thomas J. Helm, M.D.** **Pramod S. Kelkar, M.D.**

Name: ______________________________

Date of Birth: ________________________

Today's Date: ________________________

Primary physician's name: ________________________
Primary physician's address: ______________________
____

Were you referred to us by a provider? Y/N
Referring physician's name (if different): __________________
Referring physician's address: ___________________________
____

Patient- Please fill out this side:

The main problems are:

YES	NO		PHYSICIAN NOTES
☐	☐	Nasal congestion or sinus pressure	______
☐	☐	Runny nose	______
☐	☐	Itchy or watery eyes	______
☐	☐	Sneezing	______
☐	☐	Snoring	______
☐	☐	Drainage down the throat	______
☐	☐	Frequent yellow or green nasal drainage	______
☐	☐	Ear infections in the past year? How many_____	______
☐	☐	Sinus infections in the past year? How many_____	______
☐	☐	Coughing	______
☐	☐	Wheezing or shortness of breath	______
☐	☐	Diagnosis of asthma? Age______	______
☐	☐	Hospitalizations for asthma? How many_____	______
☐	☐	Emergency room visits for asthma? How many_____	______
☐	☐	School/work missed in past year for asthma______	______
☐	☐	Night time symptoms of asthma? Per week_____	______
☐	☐	Rescue inhaler use (Albuterol) Per week _______	______
☐	☐	Prednisone courses used in the past? How many_____	______
☐	☐	Reaction to food: (see page 4) yes___ no_____	______
☐	☐	Bee sting reactions	______
☐	☐	Rashes (e.g. eczema etc)	______
☐	☐	Number of pneumonias during lifetime: _____	______
☐	☐	Headaches	______
☐	☐	Vomiting, diarrhea, or abdominal pain	______
☐	☐	Transfer of allergy care from Dr. ______________	______
☐	☐	Continuation of allergy shots started____years ago	______
☐	☐	Other (explain):	______

These symptoms occur:

☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ All the time Best time of year: ____________________

Symptoms are made worse by:

☐ Cats	☐ Heat
☐ Dogs	☐ Cold
☐ Exercise	☐ Mowing Grass
☐ Colds	☐ Raking Leaves
☐ Cigarette smoke	☐ Drugs: _____________
☐ Dusting/Cleaning	☐ Other: _____________

All Current Medicines: **PHYSICIAN NOTES**

number of mg, tabs, caps, or inhaler puffs

________ ________ ______times per day ________
________ ________ ______times per day ________
________ ________ ______times per day ________
________ ________ ______times per day ________
________ ________ ______times per day ________
________ ________ ______times per day ________
________ ________ ______times per day ________
________ ________ ______times per day ________

Previous allergy or asthma medications (including OTC):

________ ☐ helped ☐ no help ________
________ ☐ helped ☐ no help ________
________ ☐ helped ☐ no help ________
________ ☐ helped ☐ no help ________
________ ☐ helped ☐ no help ________

Past Medical History:

Birth Weight: ________Problems at Birth? YES / NO ________

Surgeries:

(Age or year)

________ for ________ ________
________ for ________ ________
________ for ________ ________

Hospitalizations (other than surgery):

(Age or year)

________ for ________ ________
________ for ________ ________
________ for ________ ________
________ for ________ ________

Drug Allergies:

________ caused ________ ________
________ caused ________ ________

Immunization Adverse Reactions:

________ caused ________ ________
________ caused ________ ________

Past Allergy History: (use space at right if needed)

YES NO

☐ ☐ Previous allergy testing (If 'yes' then answer the questions below) ________

Testing by Dr.________ Year ________ ________

☐ ☐ Previous allergy shots ________

Currently on allergy injections every ___weeks ________

Do You Have:

YES	NO		YES	NO		
☐	☐	Cats	☐	☐	Cigarette smoke	________
☐	☐	Dogs	☐	☐	Wood burning stove	________
☐	☐	Birds	☐	☐	Damp basement	________
		Other pets: ________	☐	☐	Mold growth	________
☐	☐	Feather pillow	☐	☐	Room air cleaner	________
☐	☐	Down comforter	☐	☐	Whole house air cleaner	________
☐	☐	Bedroom Carpet			Workplace: ________	________

PHYSICIAN NOTES

Family History:

	Allergies	Asthma
Mother	☐	☐
Father	☐	☐
No. of Sisters _______	☐	☐
No. of Brothers _______	☐	☐
No. of Children _______	☐	☐
Grandmother (s)	☐	☐
Grandfather (s)	☐	☐
Aunt(s)	☐	☐
Uncle(s)	☐	☐
Cousin(s)	☐	☐

Other chronic family conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, immune deficiency, cancer, diabetes etc:

____

____

____

Social History:

Current occupation is: ______________________________

If child, primary residence is: ☐ one home
☐ split between homes

Activities: ______________________________

Review of Systems: (check if present)

- ☐ Problem with Growth/Weight
- ☐ Pediatric Developmental Problems
- ☐ Skin Problems
- ☐ Blood Count Problems (anemia, etc.)
- ☐ Eye Diseases (e.g. glaucoma, cataracts)
- ☐ Hearing Problems
- ☐ Thyroid Disorder
- ☐ Lung Disease (other than asthma)
- ☐ Heart Problems or High Blood Pressure
- ☐ Stomach Upset, Heartburn/Reflux
- ☐ Bowel Disorder
- ☐ Liver Disorder
- ☐ Prostate Problem
- ☐ Urinary or Bladder Problems
- ☐ Gynecologic Problems
- ☐ Mental Health Problems
- ☐ Hormone Problems (such as diabetes, menopause, etc.)
- ☐ Bones & Joints
- ☐ Cancer
- ☐ Autoimmune Disease (e.g. Lupus, Rheumatoid Arthritis)
- ☐ HIV Infection

Other comments:

____

____

____

____

Name of person filling out this history form (print): ______________________________

Relationship if not the patient: ______________________________

IF YOU ARE CONCERNED ABOUT HIVES OR FOOD ALLERGIES, PLEASE ANSWER THESE QUESTIONS:

HIVES:

PHYSICIAN NOTES

Do you have any other symptoms at the same time?
Wheezing? Y/N ______________________
Trouble swallowing? Y/N ______________________
Sensation of throat closing? Y/N ______________________

Review of Systems
History of low or high thyroid? Y/N ______________________
History of hepatitis? Y/N ______________________
History of lupus or rheumatoid arthritis? Y/N ______________________
Do you work around latex rubber products? Y/N ______________________
Do you frequently take Aspirin, Ibuprofen or NSAID's? Y/N ______________________

FOOD ALLERGY:

What are your symptoms?
Hives? Y/N ______________________
Anaphylaxis? Y/N ______________________
Wheezing? Y/N ______________________
Throat swelling or trouble swallowing? Y/N ______________________
Vomiting or abdominal pain? Y/N ______________________
Eczema? Y/N ______________________
Other symptoms? Specify______________________ ______________________
______________________ ______________________

Do you know what food causes a reaction? Y/N ______________________
Specify: ______________________ ______________________
______________________ ______________________

How soon after eating this food do the symptoms appear? ______________________
______________________ ______________________
______________________ ______________________

How much of the food do you eat before the reaction occurs? ______________________
______________________ ______________________
______________________ ______________________

Have you ever required an ER visit or hospitalization for a food reaction? Y/N ______________________ ______________________
______________________ ______________________

Have you ever had testing for food allergies? Y/N ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________