CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

PATIENT INFORMATION:

LAST NAME: _____ MI: _____ FIRST NAME: _____

GENDER: M / F SSN: _____ - _____ - _____ DATE OF BIRTH: _____ / _____ / _____

MAILING ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

PREFERRED LANGUAGE: _____ RACE/ETHNICITY: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ CITY, STATE: _____

REFERRING PHYSICIAN: _____ CITY, STATE: _____

PHARMACY NAME: _____ PHONE NUMBER: _____

IF THE PATIENT IS A MINOR OR STUDENT:

PARENT/ GUARDIAN NAME: _____ DATE OF BIRTH: _____ / _____ / _____

GENDER: M / F SSN: _____ - _____ - _____ RELATION TO PATIENT: _____

MAILING ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER: _____ MEDICAL GROUP: _____

SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S DOB: _____ / _____ / _____ SSN: _____ - _____ - _____ GENDER: M / F

MEMBER ID#: _____ EFFECTIVE DATE: _____ / _____ / _____

SECONDARY INSURANCE CARRIER: _____ MEDICAL GROUP: _____

SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S DOB: _____ / _____ / _____ SSN: _____ - _____ - _____ GENDER: M /

MEMBER ID#: _____ EFFECTIVE DATE: _____ / _____ / _____

PATIENT/ GUARDIAN SIGNATURE: _____ DATE: ____ / ____ / _____

Capital Allergy and Respiratory Disease Center
Patient Medical History Form

Patient Name: _____ Date: _____
Date of Birth: _____ Occupation: _____

Past Medical History: Do you have or have you had any of the following: (please circle answers)

Diabetes	Yes	No	High or Low Blood Pressure	Yes	No
Cancer	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Arthritis/Gout/Rheumatism	Yes	No
Convulsions	Yes	No	Blood Disease	Yes	No
Hay Fever or Asthma	Yes	No	Venereal Disease	Yes	No
Lung Disease	Yes	No			
Have you ever had a blood transfusion?	Yes	No			
Are you taking or have you ever taken steroids for any reason?	Yes	No			

Current Medications:

	Name	Dosage	Frequency	Year Started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

☐ See Attached List

Drug Allergies (please list) _____

Past Surgeries and Dates, if known:

1. _____ Year: _____ 4. _____ Year: _____
2. _____ Year: _____ 5. _____ Year: _____
3. _____ Year: _____ 6. _____ Year: _____

Have you ever been advised to have a surgical procedure that which has never been done? Yes No
If so, please state the procedure and when it was recommended? _____

Social History: (please circle the answers that are applicable)

1. Do you smoke? Yes No
If yes, how many years? _____ Number of packs per day _____
If you quit, when did you quit? _____ How many packs a day did you smoke? _____
2. Do you use recreational drugs? Yes No
3. Do you drink alcohol? Yes No
How many drinks per week? _____
4. Do you work in a noisy environment? Yes No
5. Are you frequently exposed to work place irritants (Factory, Cleaning Products etc)? Yes No
6. Have you ever been in the military? Yes No

Environmental History:

Apt/House _____ Yrs Old

Urban/Rural

Heat ☐ Central ☐ Wood ☐ Gas ☐ Heat Pump ☐ Pellet ☐ Electrical

Pets ☐ Yes ☐ No Type: _____

Smoking / ETS exposure ☐ Yes ☐ No

Reason for seeing the Doctor today:

_____

_____

How did you learn about us:

_____

_____

Family Medical History:

	Diseases Known	If deceased, cause of death
Father	_____	_____
Mother	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Grandparents		
	_____	_____
	_____	_____

Review of Systems: Please indicate if you are now experiencing any of the following. (please circle)

Recent weight change	Yes	No	Joint pain	Yes	No
Fever	Yes	No	Joint stiffness or swelling	Yes	No
Fatigue	Yes	No	Muscle pains or cramps	Yes	No
Headaches	Yes	No	Dizziness	Yes	No
Chest Pain/Angina Pectoris	Yes	No	Convulsions or Seizures	Yes	No
Heart trouble	Yes	No	Chronic or frequent coughs	Yes	No
Palpitation	Yes	No	Spitting up blood	Yes	No
Swelling of feet, ankles, hands	Yes	No	Shortness of breath	Yes	No
Slow to heal after cuts	Yes	No	Burning or painful urination	Yes	No
Bleeding or bruising tendency	Yes	No	Kidney stones	Yes	No
Anemia	Yes	No	Blood in urine	Yes	No
Diabetes	Yes	No	Incontinence	Yes	No
Excessive thirst or urination	Yes	No	Moles that are irritated or bleeding	Yes	No
Very dry, flaky skin	Yes	No	Sores that have not healed	Yes	No
Eye disease or injury	Yes	No	Rash or itching	Yes	No
Blurred or double vision	Yes	No	Change in skin color	Yes	No
Glaucoma	Yes	No	Varicose veins	Yes	No
Loss of appetite	Yes	No	Change in hair or nails	Yes	No
Frequent diarrhea, nausea or vomiting	Yes	No	Snoring	Yes	No
Abdominal pain or heartburn	Yes	No	Sleep apnea	Yes	No
Peptic Ulcer (duodenal or stomach)	Yes	No	Sinus problems	Yes	No
Memory Loss or confusion	Yes	No	Nasal Blockage	Yes	No
Nervousness	Yes	No	Hoarseness	Yes	No
Depression	Yes	No	Difficulty swallowing	Yes	No
Insomnia	Yes	No	Hearing loss or ringing in the ears	Yes	No
Thyroid Problems	Yes	No	Nose bleeds	Yes	No
			Bleeding gums or mouth sores	Yes	No

If the answer to any of these is yes, please explain:

_____

_____

_____

Patient Signature: _____ Date: _____

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

OFFICE POLICIES

PATIENT NAME: _____ DOB: _____ / ____ / _____

Thank you for choosing Capital Allergy & Respiratory Disease Center as your trusted allergy and pulmonary provider. Your health is very important to us. Please carefully read over our office policies listed on this form and if you have any questions, please ask a staff member upon check-in or by calling our main office at (916) 453-8696.

INSURANCE

- We may ask for your insurance card and identification at each visit regardless if there are any changes or not. Please be sure to bring both with you.
- Healthcare has entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Therefore, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance plan on **you**.
- We request that you become familiar with your insurance benefits and prescription coverage prior to your appointment with our office. This includes knowing which facilities can be used for radiology, laboratory, hospitalization or surgery.
- Keep in mind that insurance benefits and prescription coverage can change from year to year and plan to plan.

PATIENT / GUARDIAN INITIALS: _____

FINANCIAL

- The patient or guardian is responsible for co-payments and co-insurance at the time of service for both office visits and allergy injections.
- The patient or guardian is also responsible for deductibles, non-covered services and amounts that the insurance denies. Please become familiar with your insurance benefits prior to services being provided.
- The patient or guardian will be held financially responsible if the insurance is not in effect at the time of the visit.
- If the co-payment or co-insurance is not paid at the time of your allergy injection, you may not receive your shot. If the co-payment or co-insurance is not paid at the time of your office visit, the patient or guardian will be billed for the co-pay **plus** a $10.00 service charge.
- If there is a balance on your account, you will be asked to pay the amount in full upon your next visit to our office. A paper bill will also be sent to the mailing address on file.
- If payment has not been received within 90 days of the first billed date, the account will be sent to our collections department.
- If the patient is a minor, whoever signs this form will be held financially responsible. No exceptions.

PATIENT / GUARDIAN INITIALS: _____

STANDARD OF SERVICE

- In order to maintain a high standard of service and provide a safe environment for our patients and staff, we will not tolerate behavior of an offensive nature and reserve the right to refuse care/service to any individual who demonstrates threatening/erratic behavior or using profane and offensive language.

PATIENT / GUARDIAN INITIALS: _____

FORMS AND MEDICAL RECORDS

- Our staff is happy to fill out and/or sign forms for school, sports, work, etc. We kindly require 48-72 hours in order for the forms to be completed and picked up from our office. Please plan in advance.
- Medical records will be provided free of charge to other doctors and in instances of court hearings, such as custody or divorce proceedings.
- Other than providing medical records, our office will not provide letters or further documentation for any court hearings or disputes.
- If the patient requests their own records, there will be a fee of $15.00. The patient or guardian will be responsible to pay the fee when the medical records are picked up.
- I allow CARDC to obtain my medication history electronically on my behalf.

PATIENT / GUARDIAN INITIALS: _____

IF THE PATIENT IS A MINOR

PARENT / GUARDIAN NAME: _____

GENDER: M / F SSN: _____ - _____ - _____ DATE OF BIRTH: _____ / _____ / _____

RELATION TO PATIENT: _____ EMAIL ADDRESS: _____

MAILING ADDRESS (if different): _____ CITY: _____

STATE: _____ ZIP: _____ PHONE NUMBER: _____

By signing below, I indicate that I have received this notice and am aware of my financial responsibility for my/the patient's account.

PATIENT / GUARDIAN SIGNATURE:_____

DATE:____/____/_____

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

PATIENT NAME: ______________________________________ DOB: ____ / _____ / _______

PERMISSION TO BE INVOLVED IN PATIENT CARE

By signing this form, I authorize Capital Allergy & Respiratory Disease Center to exchange any necessary information with the person(s) named below. This may include treatment, diagnoses, test results, demographic and billing information. I also authorize the person(s) named below to make any medical decisions on my behalf if necessary.

NAME: ______________________________________ RELATION: ____________________

PHONE NUMBER: ______________________________________

NAME: ______________________________________ RELATION: ____________________

PHONE NUMBER: ______________________________________

PERMISSION TO TREAT MINOR

Our office will administer allergy injections to a minor over the age of 16. However, an adult must be present for office visits. We also allow authorized adults (such as a grandparent or babysitter) to bring a minor in for allergy injections.

By signing this form, I authorize Capital Allergy & Respiratory Disease Center to administer allergy injections to the patient under the care of the person(s) named below.

NAME: ______________________________________ RELATION: ____________________

PHONE NUMBER: ______________________________________

NAME: ______________________________________ RELATION: ____________________

PHONE NUMBER: ______________________________________

COMMUNICATION CONSENT

We cannot guarantee the confidentiality and security of an email or fax transmission. By circling ‘Y’ (Yes) below, you authorize Capital Allergy & Respiratory Disease Center to provide information via fax and/or email upon request.

Fax Number: __________________________________ OK to fax: Y / N

Email address: ________________________________ OK to email: Y / N

PATIENT / GUARDIAN SIGNATURE:____

DATE:____/____/______

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

Cancellation /No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients.

1. *Cancellation Policy*

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment.

Please contact the office no later than 24 hours prior to your scheduled appointment if you need to cancel.

2. *No Show Policy*

We understand that sometimes things come up which make it impossible to keep a scheduled appointment. We also realize that sometimes we are responsible for scheduling errors. However, when an appointment is missed and the patient does not notify our office, it results in wasted time for the clinician, and more importantly, a missed opportunity to schedule another patient. It is CARDC's policy to discontinue the care of patients after 3 missed appointments without timely notification (24 hours) of cancellation

3. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

With my ***signature*** below, I affirm that ***I have read*** and ***understand*** **CARDC's Cancellation/ NO Show Policy**

PATIENT/ GUARDIAN SIGNATURE: _____ DATE: ____ / ____ / _____

MAIN OFFICE: 5609 J STREET, SUITE C • SACRAMENTO, CA 95819 • (916) 453-8696 • FAX (916) 453-8715
FOLSOM OFFICE: 1561 CREEKSIDE DRIVE, SUITE 130 • FOLSOM, CA 95630
ROSEVILLE OFFICE: 1451 SECRET RAVINE PARKWAY, SUITE 150 • ROSEVILLE, CA 95661

Summary of Notice of Privacy Practice

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that, effective April 14, 2013,we provide you a printed copy of our Notice of Privacy Practices. For you convenience, we are providing this brief summary. A copy of our full Notice is available upon request, which we encourage you to read in it’s entirety. We are required to ask you to sign a one-time acknowledgement that you have received this summary.

Your Rights as a Patient

You have rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information

We are permitted to use your protected health information for treatment purposes, payment and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operation of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them permissible.

Disclosures of Protected Health Information Requiring Your Authorization

For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures of Protected Health Information Not Requiring Your Authorization

We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Restriction to Use and Disclosure

You may request restrictions to the use or disclosures of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, only the minimum amount of such information will be used to accomplish the intended goal.

Access to Protected Health Information

You may request access to or a copy of your medical records in writing. If we deny the request, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments to Protected Health Information

You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denial and have your objections noted in you medical record.

Accounting of Disclosures of Protected Health Information

You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment or operations.

Complaints Related to Perceived Violation of Your Privacy Rights

You may register a complaint about any of our privacy practices with our Privacy Office or with the Secretary of Health and Human Services.

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

PATIENT NAME: ____ **DOB:** _____ / ____ / _______

I hereby acknowledge that I have received a copy of Capital Allergy & Respiratory Disease Center's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Printed Name of Patient's Representative (*if applicable*)

____
Date

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

____

____

- ☐ Other (Specify)

____

____

____

____

____