CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

PATIENT INFORMATION:

Last Name: _____ MI: _____ First Name: _____

Gender: M / F / Other 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 and City: _____ Phone Number: _____

IF THE PATIENT IS A MINOR OR STUDENT:

Parent / Guardian Name: _____ Date of Birth: _____ / _____ / _____

Gender: M / F / Other 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 / Other

Member ID#: _____ Effective Date: _____ / _____ / _____

Secondary Insurance Carrier: _____ Medical Group: _____

Subscriber's Name: _____ Relation to Patient: _____

Subscriber's DOB: _____ / _____ / _____ SSN: _____ - _____ - _____ Gender: M / F / Other

Member ID#: _____ Effective Date: _____ / _____ / _____

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

Capital Allergy & Respiratory Disease Center
Patient Medical History Form

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

REASON FOR VISIT: (check all that apply)

□ Hay Fever / Seasonal Allergies □ Food Allergies □ Medication Allergies
□ Nasal Polyps / Sinus Issues □ Hives / Rash □ Swelling
□ Acute / Chronic Cough □ Itching (no rash) □ Insect Sting Allergy
□ Asthma / COPD / Wheezing □ Itching (with rash) □ Frequent Infections

If not above, please describe in your own words the reason for your visit:

_____

ALLERGY HISTORY: (check all that apply)

Do you have Environmental Allergies/Hay Fever ? □ No □ Yes, allergy triggers: _____

Do you have Eczema? □ No □ Yes Since what age? _____ Locations?_____

Do you have Asthma? □ No □ Yes Asthma triggers? □ Infection □ Exercise □ Smoke □ Allergies □ Cold Air

History of: Hospitalization? □ No □ Yes Intubation? □ No □ Yes

Emergency Dept Visits? □ No □ Yes Oral steroids in the past year? □ No □ Yes

Do you have Food Allergies? □ No □ Yes If yes, please list each food and the reactions you had:

_____

_____

_____

Do you have Drug/Medicine/Latex Allergies? □ No □ Yes If yes, please list each medication and the reactions you had:

_____

_____

_____

Do you have reactions after Bee/Wasp Stings? □ No □ Yes (don't include mosquito reaction): If yes, please describe:

_____

ENVIRONMENTAL HISTORY: (check all that apply)

Where do you live? □ Apartment □ House Age of dwelling: ____ years old Lived there for ____ years

Setting: □ Urban □ Suburban □ Rural Carpeted floors? □ No □ Yes Potted Plants? □ No □ Yes

Heating in the home: □ Central □ Wood burning □ Gas □ Heat Pump □ Pellet □ Electric

Do you have Pets at home? □ No □ Yes Types: _____

MEDICATIONS: List all prescribed, over the counter, eye drops, nasal sprays, inhalers, vitamin and supplements:

Name	Dosage	Frequency	Year Started	Name	Dosage	Frequency	Year Started

IMMUNIZATIONS (for patients <16YO): Are your vaccines up to date? □ Yes □ No, If no, reason: _____

PAST MEDICAL HISTORY: (check all that apply)

Nose: □ None □ Nasal Polyps □ Deviated Nasal Septum

Chest: □ None □ COPD □ Snoring □ Sleep Apnea □ Tuberculosis

Heart: □ None □ Heart Attack □ High Blood Pressure □ High Cholesterol

Neuro: □ None □ Stroke □ Seizures □ Anxiety/Depression

Skin: □ None □ Contact dermatitis □ Swelling/Angioedema □ Hives □ Mastocytosis

Immune: □ None □ ≥2 Pneumonias/Year □ ≥3 Sinus Infections/Year □ ≥4 Ear Infections/Year

Other: □ Diabetes □ Cataract/Glaucoma □ Arthritis/Rheumatism □ Thyroid Disease □ Cancer □ Kidney Failure

_____

_____

SURGICAL HISTORY: Please list all surgeries to date: □ None

□ Nasal/Sinus Surgery: Year _____ Reason_____ □ Tonsil/Adenoid Surgery: Year _____ Reason_____

□ Other: _____ Year _____ Reason_____ □ Other: _____ Year _____ Reason_____

_____

FAMILY HISTORY: Please list conditions in the boxes below: □ No known family medical history □ Unknown

Family Member	Age	Allergies or Asthma	Eczema or Skin Conditions	Serious or Frequent Infections	Autoimmune Diseases	Cancer	Other
Father □ Deceased							
Mother □ Deceased							
Sibling □ Deceased							
Sibling □ Deceased							
_____ □ Deceased							
_____ □ Deceased							

SOCIAL HISTORY: Occupation: _____ □ Not applicable □ Unemployed □ Retired

Do you *smoke cigarettes*? □ Never □ Current □ Former ___ packs/day, for ____ year Year quit smoking: _____

Use *smokeless tobacco*? □ Never □ Current □ Former *Vape/e-cigarettes*? □ Never □ Current □ Former

2nd Hand smoke exposure? □ No □ Yes Drink *alcohol*? □ Never □ Current □ Former

Use *recreational drugs*? □ Never □ Current □ Former Use *marijuana*? □ Never □ Current □ Former

REVIEW OF SYSTEMS: (check all that apply for any current symptoms)

General: □ None □ Fever □ Weight Loss □ Night Sweats □ Headaches □ Anxiety □ Depression

Eyes: □ None □ Contact Lens Use □ Red Eyes □ Eye Itch □ Dry Eyes □ Eye Watering □ Eye Pain □ Vision Changes

Nose: □ None □ Nose Bleeds □ Sinus Pressure □ Abnormal Nasal Discharge □ Mouth Breathing □ Loss of Smell

Mouth: □ None □ Loss of Taste □ Thrush □ Oral Ulcers

Chest: □ None □ Cough □ Wheeze □ Shortness of breath □ Chest Pain □ Palpitations

Abdomen: □ None □ Abdominal Pain □ Bloating □ Diarrhea □ Vomiting

MSK: □ None □ Joint Pain □ Joint Swelling □ Muscle Aches

Endo: □ None □ Hot Flashes □ Irregular Menses

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: ____ / ____ / _____

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)

____

____

____

____

____