



Fisher's Landing | Salmon Creek | Longview | Bellevue | Fremont | Gresham | Clackamas | San Leandro
www.columbiaallergy.com

PATIENT REGISTRATION

Today's Date: _____

Patient's Name: _____ **DOB:** _____ **Sex:** _____

Mailing Address: _____

City/State: _____ Zip code _____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____ Work Phone#: _____

Responsible Party: _____ **DOB:** _____ **Relationship:** _____

Mailing Address: _____

City/State: _____ Zip code _____ SS#: _____

Email: _____ Phone#: _____

Occupation: _____ Work Phone#: _____

Preferred Pharmacy: _____

DOES YOUR INSURANCE REQUIRE A REFERRAL? Yes: _____ No: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Ins. Address: _____ Ins. Address: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

ID#: _____ ID#: _____

Group#: _____ Group#: _____

Employer: _____ Employer: _____

Effective Date: _____ Effective Date: _____

Emergency Contact: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Columbia Asthma & Allergy Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date: _____



New Patient History Questionnaire

Date of Visit: _____ Primary Provider: _____
Patient Name: _____ DOB: _____ Gender: _____

How did you hear about our clinic?

- Advertisement (please specify): _____
- Social Media (please specify): _____
- Friend/ current patient: _____
- Referring physician: _____
- Other: _____

Briefly state what symptoms are bringing you here:

Have you ever seen a specialist (allergist, dermatologist, ENT, pulmonologist) for allergy-related problems? yes no

If yes, who? _____

Environmental Allergy Symptoms (Check all that apply)		If none, check here: <input type="checkbox"/>
<p>Nose / Sinuses / Throat</p> <input type="checkbox"/> sneezing <input type="checkbox"/> itching nose <input type="checkbox"/> congestion / stuffiness <input type="checkbox"/> runny nose (<input type="checkbox"/> clear <input type="checkbox"/> colored) <input type="checkbox"/> nose bleeds <input type="checkbox"/> snoring <input type="checkbox"/> loss of smell <input type="checkbox"/> nasal polyps <input type="checkbox"/> history of deviated septum <input type="checkbox"/> post nasal drip <input type="checkbox"/> scratchy throat <input type="checkbox"/> dry throat <input type="checkbox"/> sore throat <input type="checkbox"/> constantly clearing throat <input type="checkbox"/> headache <input type="checkbox"/> sinus pressure / pain <input type="checkbox"/> frequent sinus infections (# per year _____) <input type="checkbox"/> Nasal / Sinus Procedures (circle): surgery, sinus x-ray, sinus CT Date(s): _____	<p>Eyes</p> <input type="checkbox"/> itchy <input type="checkbox"/> watery <input type="checkbox"/> redness <input type="checkbox"/> eyelids swollen <input type="checkbox"/> sensitive to light <input type="checkbox"/> blurred vision <p>Ears</p> <input type="checkbox"/> itching <input type="checkbox"/> plugging <input type="checkbox"/> discharge <input type="checkbox"/> aching/pain <input type="checkbox"/> hearing loss <input type="checkbox"/> recurrent ear infections <p>Previous Allergy Testing/Treatment</p> <input type="checkbox"/> Allergist evaluation (Date: _____) <input type="checkbox"/> ENT evaluation (Date: _____) <input type="checkbox"/> skin testing (Last Date: _____) <input type="checkbox"/> blood testing (Last Date: _____) <input type="checkbox"/> allergy shots (for _____ years and stopped in _____ (year))	<p>Symptoms are aggravated by:</p> <input type="checkbox"/> tobacco smoke <input type="checkbox"/> exercise <input type="checkbox"/> cold air <input type="checkbox"/> animals <input type="checkbox"/> workplace or school <input type="checkbox"/> dusting or vacuuming <input type="checkbox"/> odors or scents <input type="checkbox"/> yard work <input type="checkbox"/> weather change <input type="checkbox"/> being outdoors <input type="checkbox"/> aspirin / related medications <input type="checkbox"/> other: _____ <p>Symptoms first began:</p> <input type="checkbox"/> childhood at age _____ <input type="checkbox"/> adult at age _____ <p>Symptoms occur in:</p> <input type="checkbox"/> spring <input type="checkbox"/> summer <input type="checkbox"/> fall <input type="checkbox"/> winter <p>Symptoms interfere with:</p> <input type="checkbox"/> sleep <input type="checkbox"/> work/school <input type="checkbox"/> recreation



Current Medications (Prescription, Over-the-Counter, Vitamins, Supplements, etc.)		
Medication Name: _____ _____ _____ _____ _____ _____ _____ _____	Strength / Dose / Frequency: _____ _____ _____ _____ _____ _____ _____ _____	Start Date: _____ _____ _____ _____ _____ _____ _____ _____
Previous Medications Tried: _____		

Medication / Drug Allergies		If No Drug Allergies, check here: <input type="checkbox"/>
Drug/Medication Name: _____ _____	Description of Reaction: _____ _____	Reaction Date: _____ _____

Asthma / Respiratory Problems (Check all that apply)		If none, check here: <input type="checkbox"/>
<input type="checkbox"/> Asthma diagnosed in year _____ <input type="checkbox"/> Asthma NOT diagnosed, but: <input type="checkbox"/> frequent bronchitis/croup <input type="checkbox"/> respiratory troubles as a child <input type="checkbox"/> inhalers like albuterol help <input type="checkbox"/> steroid medicine helps <input type="checkbox"/> COPD/emphysema diagnosis (year _____) <input type="checkbox"/> cough <input type="checkbox"/> dry <input type="checkbox"/> wet / mucus <input type="checkbox"/> clear, <input type="checkbox"/> yellow/green, <input type="checkbox"/> bloody <input type="checkbox"/> chest tightness <input type="checkbox"/> chest pain <input type="checkbox"/> shortness of breath <input type="checkbox"/> wheezing <input type="checkbox"/> lips and/or fingernails turn blue Symptoms first began: <input type="checkbox"/> childhood at age _____	Previous Testing/Treatment <input type="checkbox"/> Pulmonologist evaluation Last Date: _____ <input type="checkbox"/> Pulmonary function testing Date(s): _____ <input type="checkbox"/> Chest x-ray Date(s): _____ <input type="checkbox"/> ER visits • How many? _____ • Last visit: _____ <input type="checkbox"/> Hospitalized _____ times Last hospitalization: _____ <input type="checkbox"/> Oral steroids: _____ courses/year <input type="checkbox"/> Albuterol use: <input type="checkbox"/> _____ times per week <input type="checkbox"/> _____ times per month	Symptoms are aggravated by: <input type="checkbox"/> tobacco smoke <input type="checkbox"/> exercise <input type="checkbox"/> cold air <input type="checkbox"/> animals <input type="checkbox"/> workplace or school <input type="checkbox"/> dusting or vacuuming <input type="checkbox"/> odors or scents <input type="checkbox"/> yard work <input type="checkbox"/> weather change <input type="checkbox"/> being outdoors <input type="checkbox"/> aspirin / related medications <input type="checkbox"/> other: _____ Symptoms occur in: <input type="checkbox"/> spring <input type="checkbox"/> summer <input type="checkbox"/> fall <input type="checkbox"/> winter Symptoms interfere with: <input type="checkbox"/> sleep <input type="checkbox"/> work/school <input type="checkbox"/> recreation



adult at age _____

Skin Problems (Check all that apply)		If none, check here: <input type="checkbox"/>
<input type="checkbox"/> itching <input type="checkbox"/> dry, scaly skin <input type="checkbox"/> eczema <input type="checkbox"/> welts, hives <input type="checkbox"/> rash <input type="checkbox"/> skin swelling <input type="checkbox"/> recurrent skin infections Location of skin problems: _____	Symptoms first began: <input type="checkbox"/> childhood at age _____ <input type="checkbox"/> adult at age _____ Previous Testing/Treatment <input type="checkbox"/> Dermatologist evaluation Last Date: _____ <input type="checkbox"/> medications (see medication list) <input type="checkbox"/> moisturizers <input type="checkbox"/> other: _____	Symptoms are made worse by: _____ _____ _____ Symptoms interfere with: <input type="checkbox"/> sleep <input type="checkbox"/> work/school <input type="checkbox"/> recreation

Food Allergies	If No Food Allergies, check here: <input type="checkbox"/>	
Previous food allergy testing? <input type="checkbox"/> no <input type="checkbox"/> yes (If yes, <input type="checkbox"/> skin test <input type="checkbox"/> blood test Date(s): _____)		
Food(s) Causing Reaction: _____ _____ _____	Description of Reaction: _____ _____ _____ _____	Reaction Date: _____ _____ _____

Latex, Insect Stings, Chemicals, and Other Allergic Reactions	If No Other Allergies, check here: <input type="checkbox"/>	
Item Causing Reaction: _____ _____	Description of Reaction: _____ _____	Reaction Date: _____ _____

Other Past Medical History
Immunizations: <input type="checkbox"/> up to date <input type="checkbox"/> not up to date Have you received: 1)Flu vaccine in past year: <input type="checkbox"/> yes <input type="checkbox"/> no 2)Pneumonia vaccine: <input type="checkbox"/> yes in _____(year) <input type="checkbox"/> no
Surgeries / Hospitalizations (details and date): _____
Other Medical Conditions: <input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Other Lung Diseases _____ <input type="checkbox"/> GERD <input type="checkbox"/> Other _____



Family History table with columns: Hayfever / Allergies, Sinus Trouble, Asthma, Frequent Bronchitis, Eczema, Hives, Migraine Headaches, Thyroid Disease, Food Allergies, Other. Rows for Father, Mother, Brother(s), Sister(s), Child(ren), Grandparent(s). Includes checkbox for 'If Unknown, check here:'. Below table: Autommune Disease (in any relatives):

Social History section with fields for Occupation, Recent Travel History, Marital Status (Single, Married, Divorced/Sep, Widowed), Exercise, Hobbies, Special Diet?, Current smoker?, Past smoker?, Alcohol Use, and Recreational Drug Use.

Environmental History section with fields for Primary residence (House, Apartment/Condo/Townhouse, Mobile Home), Location (city/suburban, rural), Residence age, Heating (central, electric, gas, radiator, wood fireplace, gas fireplace), Air Conditioning, Filter System, Humidifier, Flooring (In main areas, In bedroom), Bed (mattress/boxspring, latex, foam, waterbed, other), and Pillows (feather, non-feather).



Sanjeev Jain MD, PhD

Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that required that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA," we have prepared this explanation of how we are required to maintain, use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- 1) **Treatment:** We may use your medical information to obtain payment for the services we provide, including confirming coverage and other billing or collecting activities.
- 2) **Payment:** We may use and disclose your medical information to obtain payment for the services we provide, including confirming coverage and other billing or collecting activities.
- 3) **Healthcare Operations:** We may use and disclose your medical information for our normal health care operations, such as conducting quality assessment and improvement activities, auditing functions and legal services.

In addition, we may use and disclose your medical information to contact and remind you about appointments. We may leave this information on your answering machine or in a message left with the person answering the phone or in an email. In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may use and disclose your medical information by having you sign in when you arrive at our office. We may call out your name when we are ready to serve you.

Any other uses and disclosures will be made only with your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

By presenting a written request, you have the following rights with respect to your protected health information:

- 1) The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, or any other persons identified by you. We are, however, not required to agree to a request restriction.
- 2) The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- 3) The right to inspect and copy your protected health information.
- 4) The right to amend your protected health information. We are, however, not required to change :

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health information, and will provide you with information about our denial.

5) The right to receive an accounting of disclosures of protected health information.

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We will inform you of any change and may request a written copy of a revised Notice of Privacy from us.

If you feel that your privacy protections have been violated, you have the right to file written complaint with our office. If you are not satisfied with the manner in which this office handles you complaint, you may also submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201

This notice goes into effect as of April 14, 2003

Acknowledgement of Receipt of Notice of Privacy Policies

I hereby acknowledge that I read the above Notice of Privacy Practices from Columbia Asthma and Allergy Clinic.

Patient Name: _____

Signature: _____ Date: _____

Parent or guardian's name if not signed by the patient: _____

Relation to the Patient: _____



Financial Policy

Method of Payment:

We accept cash, checks, and all credit cards for your convenience.

New Patients:

For new patients without insurance coverage, we expect payment in full at the time of service. For all patients with insurance, we require that co-pays be paid in full at the time of service, and we may ask for the estimated co-insurance or deductible for additional services to be paid at the time services are rendered.

Billing for Insurance Accounts:

If your insurance company pays differently for any reason that what was estimated prior to treatment, it is understood that you are responsible to pay any remaining balance within 30 days of notification by your insurance company. *If after 60 days from filing your claim we have not received payment from your insurance carrier, we will ask you to pay the remaining balance on your account.*

Appointment Failures and Cancellations:

We require 48 hour notice of change of appointment or cancellation. We appreciate you as a patient, and cooperation in complying with this policy will assist us in providing the best care possible to all our patients. Failure to comply with this policy three times results in a \$25.00 charge for each missed appointment thereafter.

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of my insurance benefits be made to my physician.

- authorize the billing department to leave a voice message on my answering machine at home.
- authorize the billing department to leave a voice message on my cell phone.

I have read the above financial policies and agree to abide by them to the best of my ability.

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

Patient Signature: _____

Parent/Guardian Signature (Patient under 18): _____



Patient Name: _____ DOB: _____ Today's Date: _____

REVIEW OF SYSTEMS

We need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the nurses or providers.

Constitutional (Health in General) No Problems --- Fatigue, unexplained weight gain or weight loss, fever, chills, night sweats. Other: _____

Allergic/Immunologic No Problems --- Seasonal allergies, year-round allergies, frequent infections. Other: _____

Eyes No Problems --- Eye pain, redness, itching, irritation, discharge, light sensitive, blurred vision. Other: _____

Ears, Nose, Mouth & Throat No Problems --- Ear pain, hearing loss, frequent ear infections, ringing in ears, nasal congestion, runny nose, nose bleeds, post nasal drip, hoarseness, frequent sore throats, snoring. Other: _____

Resp. (Lungs & Breathing) No Problems --- Shortness of breath, cough, wheezing, sputum production, problems with exercise. Other: _____

C-V (Heart & Blood Vessels) No Problems --- Elevated blood pressure, chest pain, heart palpitations, swelling of feet or legs, dizziness. Other: _____

GI (Stomach & Intestines) No Problems --- Abdominal pain, nausea, vomiting, diarrhea, constipation, heartburn, difficulty swallowing, blood in stools, bloating. Other: _____

Integ. (Skin, Hair & Breast) No Problems --- Rash, itching, hives, swelling, eczema, hair changes, dry skin. Other: _____

MS (Muscles, Bones, Joints) No Problems --- Joint pain/stiffness/swelling, muscle pain/cramps, muscle or joint weakness. Other: _____

Endocrinologic (Glands) No Problems --- Intolerance to heat or cold, frequent urination or thirst. Other: _____

Psychiatric (Mood & Thinking) No Problems --- Depression, anxiety, mood swings, unusual irritability, poor concentration. Other: _____

GU (Kidney & Bladder) No Problems --- Painful urination, frequent urination, urgency. Other: _____

Cancer: No Problems --- Prior diagnosis of Cancer: _____

Hematologic (Blood/Lymph) No Problems --- Easy bleeding, easy bruising, anemia, abnormal blood tests, unexplained swollen areas, blood clots. Other: _____

Neurologic (Brain & Nerves) No Problems --- Headaches, weakness, change in sensation, dizziness, memory loss, seizures, loss of consciousness. Other: _____

Any other unexplained symptoms: _____