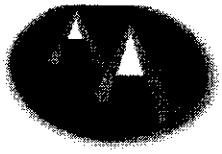


Columbia Asthma & Allergy CLINIC

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: _____

Columbia Asthma & Allergy CLINIC

Sanjeev Jain, MD, PhD | Stephen Fritz, MD | Jon Welch MD | Michael Noonan, MD
Paul Cheng, MD, PhD | Renu Gandhe, MD | Umesh Sab, MD | Melissa Hutton, PA-C
www.ColumbiaAllergy.com

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: ❑

Nose / Sinuses / Throat
- ❑ sneezing
- ❑ itching nose
- ❑ congestion / stuffiness
- ❑ runny nose (❑clear ❑colored)
- ❑ nose bleeds
- ❑ snoring
- ❑ loss of smell
- ❑ nasal polyps
- ❑ history of deviated septum
- ❑ post nasal drip
- ❑ scratchy throat
- ❑ dry throat
- ❑ sore throat
- ❑ constantly clearing throat
- ❑ headache
- ❑ sinus pressure / pain
- ❑ frequent sinus infections (# per year_____)
- ❑ Nasal / Sinus Procedures (circle): surgery, sinus x-ray, sinus CT Date(s):_____

Eyes
- ❑ itchy
- ❑ watery
- ❑ redness
- ❑ eyelids swollen
- ❑ sensitive to light
- ❑ blurred vision

Ears
- ❑ itching
- ❑ plugging
- ❑ discharge
- ❑ aching/pain
- ❑ hearing loss
- ❑ recurrent ear infections

Previous Allergy Testing/Treatment
- ❑ Allergist evaluation (Date:_____)
- ❑ ENT evaluation (Date:_____)
- ❑ skin testing (Last Date:_____)
- ❑ blood testing (Last Date:_____)
- ❑ allergy shots (for ____ years and stopped in _____ (year)

Symptoms are aggravated by:
- ❑ tobacco smoke
- ❑ exercise
- ❑ cold air
- ❑ animals
- ❑ workplace or school
- ❑ dusting or vacuuming
- ❑ odors or scents
- ❑ yard work
- ❑ weather change
- ❑ being outdoors
- ❑ aspirin / related medications
- ❑ other: _____

Symptoms first began:
- ❑ childhood at age _____
- ❑ adult at age _____

Symptoms occur in:
- ❑ spring ❑ summer
- ❑ fall ❑ winter

Symptoms interfere with:
- ❑ sleep ❑ work/school
- ❑ recreation

Columbia Asthma & Allergy CLINIC

Sanjeev Jain, MD, PhD
Paul Cheng, MD, PhD
Stephen Fritz, MD
Renu Gandhe, MD
Jon Welch MD
Umesh Sab, MD
Michael Noonan, MD
Melissa Hutton, PA-C

www.ColumbiaAllergy.com

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: ❑

Drug/Medication Name:	Description of Reaction:	Reaction Date:

Asthma / Respiratory Problems (Check all that apply)

If none, check here: ❑

❑ Asthma diagnosed in year _____
❑ Asthma NOT diagnosed, but:
- ❑ frequent bronchitis/croup
- ❑ respiratory troubles as a child
- ❑ inhalers like albuterol help
- ❑ steroid medicine helps

❑ COPD/emphysema diagnosis (year_____)
❑ cough
- ❑dry
- ❑ wet / mucus
  - ❑clear, ❑yellow/green,
  - ❑bloody

❑ chest tightness
❑ chest pain
❑ shortness of breath
❑ wheezing
❑ lips and/or fingernails turn blue

Symptoms first began:
❑ childhood at age _____

Previous Testing/Treatment
❑ Pulmonologist evaluation
Last Date:_____
❑ Pulmonary function testing
Date(s):_____
❑ Chest x-ray
Date(s):_____

❑ ER visits
- How many?_____
- Last visit:_____

❑ Hospitalized _____ times
Last hospitalization:_____

❑ Oral steroids: ____ courses/year
❑ Albuterol use:
- ❑ ____ times per week
- ❑ ____ times per month

Symptoms are aggravated by:
❑ tobacco smoke
❑ exercise
❑ cold air
❑ animals
❑ workplace or school
❑ dusting or vacuuming
❑ odors or scents
❑ yard work
❑ weather change
❑ being outdoors
❑ aspirin / related medications
❑ other: _____

Symptoms occur in:
❑ spring ❑ summer
❑ fall ❑ winter

Symptoms interfere with:
❑ sleep ❑ work/school ❑ recreation

Columbia Asthma & Allergy CLINIC

Sanjeev Jain, MD, PhD · Stephen Fritz, MD · Jon Welch MD · Michael Noonan, MD
Paul Cheng, MD, PhD · Renu Gandhe, MD · Umesh Sab, MD · Melissa Hutton, PA-C
www.ColumbiaAllergy.com

❑ adult at age _____		

Skin Problems (Check all that apply) — If none, check here: ❑

❑ itching
❑ dry, scaly skin
❑ eczema
❑ welts, hives
❑ rash
❑ skin swelling
❑ recurrent skin infections

Location of skin problems:
_____

Symptoms first began:
❑ childhood at age _____
❑ adult at age _____

Previous Testing/Treatment
❑ Dermatologist evaluation
Last Date:_____
❑ medications (see medication list)
❑ moisturizers
❑ other:_____

Symptoms are made worse by:
_____
_____
_____

Symptoms interfere with:
❑ sleep ❑ work/school
❑ recreation

Food Allergies — If No Food Allergies, check here: ❑

Previous food allergy testing? ❑no ❑yes (If yes, ❑skin test ❑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: ❑

Item Causing Reaction:	Description of Reaction:	Reaction Date:

Other Past Medical History

Immunizations: ❑ up to date ❑ not up to date
Have you received: 1)Flu vaccine in past year: ❑ yes ❑ no 2)Pneumonia vaccine: ❑ yes in _____(year) ❑ no

Surgeries / Hospitalizations (details and date):_____

Other Medical Conditions: ❑ None

❑ Diabetes
❑ Seizures
❑ Heart Disease
❑ High Blood Pressure
❑ GERD
❑ Thyroid Disease
❑ Kidney Disease
❑ Liver Disease
❑ Other Lung Diseases_____
❑ Other_____

Columbia Asthma & Allergy Clinic

Sanjeev Jain, MD, PhD | Stephen Fritz, MD | Jon Welch MD | Michael Noonan, MD
Paul Cheng, MD, PhD | Renu Gandhe, MD | Umesh Sab, MD | Melissa Hutton, PA-C
www.ColumbiaAllergy.com

Family History

If Unknown, check here: ❑

	Father	Mother	Brother(s)	Sister(s)	Child(ren)	Grandparent(s)
Hayfever / Allergies:	❑	❑	❑	❑	❑	❑
Sinus Trouble:	❑	❑	❑	❑	❑	❑
Asthma:	❑	❑	❑	❑	❑	❑
Frequent Bronchitis:	❑	❑	❑	❑	❑	❑
Eczema:	❑	❑	❑	❑	❑	❑
Hives:	❑	❑	❑	❑	❑	❑
Migraine Headaches:	❑	❑	❑	❑	❑	❑
Thyroid Disease:	❑	❑	❑	❑	❑	❑
Food Allergies:	❑	❑	❑	❑	❑	❑
Other:_____	❑	❑	❑	❑	❑	❑

Autommune Disease (in any relatives):_____

Social History

Occupation:_____
Recent Travel History:_____
Marital Status: ❑Single ❑Married ❑Divorced/Sep. ❑Widowed
Exercise:_____
Hobbies:_____
Special Diet?:_____

Current smoker? ❑no ❑yes, ___ packs per day
Past smoker? ❑no ❑yes, ___ packs per day for ___ years. Quit in _____.
Alcohol Use: ❑None ❑1-5 drinks per week ❑More than 5 drinks per week
Recreational Drug Use (confidential): ❑yes ❑no

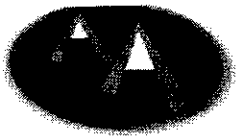
Environmental History

Primary residence: ❑House ❑Apartment/Condo/Townhouse ❑Mobile Home **Location**: ❑city/suburban ❑rural
Residence is ____ years old and have lived there for ___ years.
Previously lived in (city/state/country):_____

Does your home have a basement? ❑no ❑yes
(if yes, ❑finished ❑unfinished ❑dry ❑damp ❑musty)
History of water damage in home? ❑no ❑yes
Is there mold visible in the home? ❑no ❑yes
Smokers in the home? ❑no ❑yes

Pets: ___dog(s) ___cat(s) Other:_____
❑indoor ❑outdoor ❑allowed in bedroom

Heating: ❑central ❑electric ❑gas ❑radiator ❑wood fireplace ❑gas fireplace
Air Conditioning: ❑central ❑in-window ❑fans
Filter System: ❑yes ❑no
Humidifier: ❑yes ❑no
Flooring:
In main areas: ❑carpet ❑laminate ❑hardwood
In bedroom: ❑carpet ❑laminate ❑hardwood
Bed: ❑mattress/boxspring ❑latex ❑foam ❑waterbed ❑other_____
(Allergy encasement? ❑yes ❑no)
Pillows: ❑feather ❑non-feather
(Allergy encasements? ❑yes ❑no)



Columbia Asthma & Allergy CLINIC

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 u or disclose your health information for another purpose, you may evoke your authorization in writing at any time.

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

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 ide 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 infor 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

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: _____

Asthma & Allergy CLINIC

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): _____

Sanjeev Jain MD, PhD
www.ColumbiaAllergy.com

Columbia Asthma & Allergy CLINIC

www.ColumbiaAllergy.com

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: _____