

Allergy and Asthma Center of Montana, PC

401 15th Ave S. Suite 104 Great Falls, MT 59405

Phone (406) 771-9050 Fax (406) 761-1090

PATIENT REGISTRATION

(Please print clearly)

Full Name _____ DOB _____ Male/Female
Address _____ City/State/Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Social Security # _____ Employer _____
Pharmacy of Choice _____ Occupation _____

Status: Single Married Divorced Widowed

Race: American Indian Asian Native Hawaiian Black or African American White Hispanic Other Race

Ethnicity: Hispanic Non Hispanic

Language: English Indian Spanish Russian Tagalog Thai Other _____

Parent and/or Spouse's Name _____ DOB _____
Social Security # _____ Phone # _____
Employer _____ Employer Phone _____

Primary Provider _____ Referring Provider _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Policy Holder _____
CoPay _____ Social Security # _____ Date of Birth _____
Subscriber # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Policy Holder _____
CoPay _____ Social Security # _____ Date of Birth _____
Subscriber # _____ Group # _____

INFORMED CONSENT FOR TREATMENT

I understand that I am now under the care and supervision of the providers of Allergy and Asthma Center of Montana, PC. I understand that it is the responsibility of Allergy and Asthma Center of Montana, PC and its staff to carry out the instructions of the providers. I consent to medical/allergy testing services rendered to me and the expressed or implied instruction of my provider. I understand that any services furnished to me outside of the scope of any instruction, express or implied, of my provider or designee are not performed on behalf of , or at the direction of Allergy and Asthma Center of Montana, PC.

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with above listed insurance company and assign directly to Allergy and Asthma Center of Montana, PC all insurance benefits. If any otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges on all insurance submissions. The above named facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or in one year from the signed date below.

Signature of Patient or Patient Representative

Date

**AUTHORIZATION FOR RELEASE OF INFORMATION
ALLERGY AND ASTHMA CENTER OF MONTANA, P.C.**

401 – 15th Avenue South, Suite 104
Great Falls, MT 59405-4334
Office: (406)771-9050 Fax: (406)761-1090

Patient Name _____ Date of Birth _____

I hereby authorize (FROM) Dr. Elaine Barbieri to release my personal health and medical information as described below to _____

Information to be disclosed:

Complete Health Records
ALL Laboratory tests information
Radiology Reports

Consultation Reports
Progress Notes
Discharge Summary _____

Films
Other _____

From (date) _____ To (date) _____

I understand that this will include information relating to (check if applicable):

____ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
____ Behavioral health services/psychiatric care

What is the purpose or use of the disclosure? _____

The patient or patient's representative MUST read and initial the following statements:

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Initial _____

I understand that I may inspect or receive a copy of the information described on this form if I ask for it and that I will receive a copy of this form after I sign it.

Initial _____

Unless otherwise canceled, I understand that this authorization will expire after 12 months or on the following date, event or condition: _____.

Initial _____

I understand that I may cancel this authorization at any time by notifying the providing health care provider in writing, but if I do, it will not have any effect on actions taken prior to receipt of the cancellation.

Initial _____

I understand that if the person or entity that receives the above information is not a health care provider or a health plan provider covered by federal privacy regulations the released information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from re-disclosing substance abuse information, AIDS/HIV status or mental health information unless another authorization is obtained by me or unless such use or disclosure is specifically required or permitted by law.

Initial _____

(Signature/name of patient and/or patient representative) Date: _____

If signed by other than patient, indicate relationship: _____

Signature of Physician: _____ Witness: _____ Date: _____

Allergy and Asthma Center of Montana, PC

401 15th Ave S. Suite 104 Great Falls, MT 59405

Phone (406) 771-9050 Fax (406) 761-1090

Prescription Consent

I give my consent to have Asthma and Allergy Center of Montana obtain my prescription history from external sources.

Signature of Patient or Patient Representative

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the Allergy and Asthma Center of Montana's Notice of Privacy practices.

Signature: _____ Date: _____

EMAIL AUTHORIZATION AGREEMENT

Allergy and Asthma Center of Montana may choose to discontinue e-mail communication at any time.

Privacy and Security of E-mail

Do not use e-mail to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, and e-mail sent on your employer's system may be viewed by your employer.

Asthma and Allergy Center of Montana cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail.

This document along with Allergy and Asthma Center of Montana "Notice of Privacy Practices" constitutes a notice of privacy practice for e-mail use.

Authorization to use e-mail

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with my physician, and his/her associates, technicians and other healthcare providers.

You will be given a copy of this signed form to keep for your records.

Patient Signature _____ Date _____

Patient e-mail address _____

Allergy and Asthma Center of Montana, PC

401 15th Ave S. Suite 104 Great Falls, MT 59405

Phone (406) 771-9050 Fax (406) 761-1090

PAYMENT POLICY

1. **Billing Insurance:** It will be our pleasure to bill your insurance company for you, provided that you submit accurate billing information.
2. **Co-Pays:** Co-Pays are expected at the time of services, no exceptions. It is your contractual agreement with your insurance to pay your co-pay at the time of service.
3. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will be automatically billed to you with the payment expected within 30 days.
4. **Nonpayment:** If your account is over 60 days past due, we will expect payment in full before further treatment is provided by our facility. Understand that you will be charged a late fee of \$10.00 a month for accounts that are past due. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.
5. **Missed Appointments:** Please notify us of a canceled appointment at least 24 hours prior to your appointment time. Our policy is to charge up to \$100.00 fee for missed appointments or appointments canceled without 24 hour notice. These charges will be your responsibilities and billed directly to you.
6. **Payments:** If you are currently without insurance coverage, we offer a discount for payment in full at the time of service. We accept payments by cash, check, or credit card.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR ALL CHARGES, REGARDLESS OF INSURANCE OR OTHER THIRD PARTY COVERAGE.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

Signature of Patient **DATE:** _____

Printed Name of Patient **DATE:** _____

NEW PATIENT HISTORY

AGE: _____
REFERRING PHYSICIAN _____ PHONE #: () _____ - _____
REFERRING PHYSICIAN ADDRESS:

REASON FOR TODAY'S VISIT:

DRUG ALLERGIES	REACTION

This questionnaire is divided into sections based on your possible different allergic problems. Please fill out as best you can the sections that apply to your conditions.

- Medication list for everyone to complete.....page 2**
- Allergies bothering the eyes, nose or throat or ears..... page 3-4**
- Food allergies.....page 4**
- Asthma or breathing troubles.....page 4-5**
- Hives/angioedema (allergic type swelling).....page 5-6**
- Bee sting/insect bite reactions or latex reactions.....page 5**
- Eczema/allergic rashes.....page 6**
- General history questions for everyone to complete.....page 6-10**
- Work exposure history (complete if indicated).....page 11**

FORM COMPLETED BY: _____ DATE: _____

CURRENT MEDICATION LIST

NAME OF MEDICATION	DOSE / STRENGTH	HOW OFTEN

OVER THE COUNTER/ VITAMIN / HERBAL SUPPLEMENTS

NAME OF MEDICATION	DOSE / STRENGTH	HOW OFTEN

Please circle all that apply to your allergic nose, eye, throat or ear symptoms:

- | | | | | |
|------------------------|----------------|-------------------------|-----------------|--------------|
| Nasal itching | Sneezing | Post nasal drip | | |
| Nasal congestion | Nasal drainage | Sore throat | Throat itching | Hoarse voice |
| Ear pain/ pressure | Ear popping | Ear itching | Hearing changes | |
| Fluid behind ears | Ear ringing | Ear drainage | Dizziness | |
| Eye redness | Eye itching | Eyelid swelling | Eye watering | |
| Eye pain | Vision changes | Dark circles under eyes | | |
| Loss of taste or smell | | Sinus pain | | |

If **YES** to any of the above questions, how long have these symptoms been present?

If **YES** to any of the above questions, how often do your symptoms occur (# of times per day, week, etc.,)

Are your symptoms worse at any particular time of the year? (circle one) **YES** **NO**

If YES, **Please circle which months are worse,**

- | | | | | | |
|---------|----------|-----------|---------|----------|----------|
| January | February | March | April | May | June |
| July | August | September | October | November | December |

Symptoms are worse: **(Check all that apply)**

- | | | |
|----------------------------------|------------------------------------|---|
| <input type="checkbox"/> At home | <input type="checkbox"/> At school | <input type="checkbox"/> At work |
| <input type="checkbox"/> Indoors | <input type="checkbox"/> Outdoors | <input type="checkbox"/> Other Location _____ |

Please **Mark any** of the following that make your **symptoms worse.**

- | | |
|--|---|
| <input type="checkbox"/> Fresh cut grass | <input type="checkbox"/> High pollution days |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Air conditioning |
| <input type="checkbox"/> Damp areas | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Entering a basement | <input type="checkbox"/> Cats |
| <input type="checkbox"/> House plants | <input type="checkbox"/> Dogs |
| <input type="checkbox"/> Barns/hay | <input type="checkbox"/> Other animals _____ |
| <input type="checkbox"/> Wet weather | <input type="checkbox"/> Soap |
| <input type="checkbox"/> Dry weather | <input type="checkbox"/> Perfumes |
| <input type="checkbox"/> Wind | <input type="checkbox"/> Paint fumes |
| <input type="checkbox"/> Hot day | <input type="checkbox"/> Chemical odors |
| <input type="checkbox"/> Cold day | <input type="checkbox"/> News papers |
| <input type="checkbox"/> Weather change | <input type="checkbox"/> Other strong odors _____ |

What medications have you tried for treatment of you symptoms? Indicate if you think the medication improved your symptoms.

Medication	Result

Have you ever been evaluated by an allergist? (Circle one) **YES** **NO**
 If YES, who was your previous allergist? _____
 Have you ever had allergy skin testing or blood testing done? (Circle one) **YES** **NO**
 If YES, what were the positive reactions? _____

IF POSSIBLE, PLEASE BRING IN PREVIOUS ALLERGY RECORDS OR HAVE THESE SENT TO OUR OFFICE FOR YOUR VISIT.

Have you ever been treated with allergy shots? (Circle one) **YES** **NO**
 If YES, did the allergy shots help you? (Circle one) **YES** **NO**
 What years were the shots taken? _____
 Did you have any serious reactions to the shots? **YES** **NO**
 If YES, please explain _____

Have you had any problems after eating certain foods? (Circle one) **YES** **NO**
 If YES, please write down the type of food, and the type of reaction below:

Food	Reaction

Have you been diagnosed with asthma? **YES** **NO**
 If yes, how often do you use your rescue medicine (for example Albuterol)? _____

Do you have problems with any of the following?

COUGH? **YES** **NO**

COUGHING UP MUCUS OR PHLEGM? **YES** **NO**

WHEEZING? **YES** **NO**

SHORTNESS OF BREATH? **YES** **NO**
 At rest? **YES** **NO** With activity **YES** **NO**

COUGHING UP BLOOD FROM YOUR LUNGS? **YES** **NO**

Is your coughing, wheezing or shortness of breath worse at certain times of the year? **YES** **NO**
 If YES, please specify which months. **Please circle all that apply.**

January February March April May
 June July August September October
 November December

What seems to trigger your coughing, wheezing or shortness of breath? **Please circle your answer.**

Exposure to:

Cold	Heat	Humidity	Quick weather changes	Smoke
Dust	Mold	Grass	Weeds	Strong odors
Cats	Dogs	Other animals	_____	Physical activity
Upper respiratory infections	Other	_____		

DO YOU HAVE TROUBLE WITH CHEST PAIN?

YES NO

If YES, is it: Sharp Dull Tight Pressure Stabbing

Where is the pain specifically located _____

How long have you had this pain? _____ # days _____ # weeks _____ # years

PULMONARY TEST RESULTS

Have you ever had:

Chest X-ray?	YES	NO	If YES, when? _____	where? _____
Chest CAT scan	YES	NO	If YES, when? _____	where? _____
Breathing test? (PFT)	YES	NO	If YES, when? _____	where? _____
Sleep study?	YES	NO	If YES, when? _____	where? _____
Exercise test?	YES	NO	If YES, when? _____	where? _____

Have you ever had hives, urticaria, welts or problems with swelling of your lips, tongue, throat, hands or feet?

YES NO If YES, please describe:

Have you had any reactions after an insect bite or bee, wasp, yellow jacket, hornet or fire ant sting?

YES NO If YES, please describe:

Have you ever had problems after exposure to latex (gloves, balloons, rubber products, condoms, etc.)?

YES NO If YES, please describe:

Do you have a history of eczema or atopic dermatitis?

YES NO If YES, please describe where you get a rash and what treatment has been tried.

Have you ever had contact dermatitis? (A rash after something touches your skin, such as certain metals or poison ivy)

YES NO If YES, Please describe.

Have you ever had a reaction after an immunization/vaccine?

YES NO If YES, please describe. _____

PAST MEDICAL HISTORY

Please Circle all that apply to your past or current medical history

- | | | |
|------------------------------------|------------------------------------|------------------------|
| Allergies/hay fever | Endometriosis | Osteoporosis |
| Anemia | Glaucoma | Pleural fluid/effusion |
| Aneurysm | Heart attack | Pneumonia |
| Arthritis | Heartburn/reflux | Polio |
| Asthma/Wheezing | Heart failure Heart valve problems | Prostate problems |
| Back pain-recurrent | Heart valve problems | Psychiatric problems |
| Bleeding tendencies/ bruise easily | Hepatitis/liver disease | Recurring infections |
| Blood clots | Herpes | Rheumatic fever |
| Bronchitis | High blood pressure | Rheumatoid arthritis |
| Cancer, type _____ | High cholesterol | Sinus infections |
| Cataracts | HIV positive or AIDS | Sleep apnea |
| Chest injury | Irregular heart beat | Skin infections |
| Collapsed lung | Kidney disease | Stomach ulcers |
| Convulsions/Seizures | Lupus | Thyroid disease |
| COPD/Emphysema/chronic bronchitis | Meningitis/brain infection | Stroke |
| Cystic Fibrosis | Migraine headaches | Tuberculosis (TB) |
| Depression | Neurological problems | Ulcers |
| Diabetes | Nasal or sinus polyps | Varicose veins |
| | | Venereal disease |

Have you ever been on a ventilator (life support breathing machine)

YES NO

If YES, when and for what? _____

Do you have other conditions requiring regular medical attention?

Problem	Year

GASTROINTESTINAL / LIVER:

Abdominal pain Blood in stool Constipation Diarrhea
Pain with swallowing Difficulty swallowing Heartburn Nausea Vomiting

RENAL / URINARY:

Blood in urine Difficulty urinating Frequent urination
Nighttime urination Incontinence Decreased stream Hesitancy

MUSCULOSKELETAL:

Joint pain Joint stiffness Joint swelling Muscle ache

NEUROLOGICAL:

Double vision Seizures Numbness/tingling Dizziness
Memory loss Headache

PSYCHOLOGICAL:

Personality change Anxiety Depression Suicidal thoughts
High stress level Sleep disturbance

MALE GENITAL-REPRODUCTIVE:

Infertility Erectile dysfunction

FEMALE GENITAL-REPRODUCTIVE:

Breast pain Nipple discharge Frequent yeast infections Infertility Contraception

YOUR SOCIAL HISTORY AND HABITS

Have you ever used any of the following?

↑ Cigarettes _____ packs/day _____ # of years.
↑ Pipe _____ hours/day _____ # of years.
↑ Cigars _____ number/day _____ # of years.
↑ Chewing tobacco
↑ Snuff

Are you currently smoking? **YES** **NO** If previous smoker, year quit? _____

Interested in stopping? **YES** **NO**

Have you had significant exposure to other people smoking cigarettes? **YES** **NO**

If YES, who, how much and for how long?

↑ Alcohol: Type: _____ Amount: _____ How often _____

↑ Street drugs: (including Cocaine, Marijuana, Heroin or Meth)
What: _____ When: _____ How often _____

Occupation _____

Marital Status: Married Single Divorced Widowed Other

Any work exposure to asbestos, hard rock mining, factory, flour, chemicals, welding etc.? **YES** **NO**
If YES, what : _____ When: _____

Have you ever lived outside of Montana? **YES** **NO**
If YES, where: _____ when: _____
how long _____

FAMILY MEDICAL HISTORY
(Check all that apply)

	Father	Mother	Children	Brother	Sister	Other blood relative
Allergies/ Hay fever						
Angioedema (allergic swelling)						
Arthritis						
Asthma						
Bleeding disorder						
Blood clots						
Cancer						
Cystic fibrosis						
COPD/Emphysema/Chronic bronchitis						
Diabetes						
Eczema						
Heart disease						
High blood pressure						
Hives (Urticaria)						
Immunodeficiency (recurrent infections)						
Interstitial lung disease						
Kidney disease						
Lupus						
Pulmonary fibrosis						
Rheumatoid arthritis						
Stroke						
Other:						

This next section should be filled out as completely as possible to help your physicians better assess your condition. This portion will tell us about other possible areas which could be causing you discomfort.

In what type of dwelling do you live? Please **circle** your answer.

House

Town house

Condominium

Apartment

Flat

Mobil home

What is the age of your dwelling? _____ years old

How long have you lived there? _____ years _____ months

Circle the one best answer: Your dwelling is built over:

A crawl space

A cement slab

A full basement

A partial basement and crawl space

A partial basement and cement slab

Describe the basement or crawl space: **Circle more than one if applicable.**

Wet

Has a musty odor

Has a cement floor

Dry

Never musty

Has a tiled floor

Sometimes wet or damp

Has a carpeted floor

Is covered with plastic sheeting

What type of fuel do you use for heating? **Circle more than one if applicable.**

Natural gas Electric Wood Fuel oil

What type of heat system does your home have? **Please circle you answer.**

Forced air Baseboard hot water Steam radiators Central stove or heater
Electric radiators or heater Heat pump

Please **circle any** of the following that you use in your home:

Central air conditioning Room air conditioning Swamp cooler Ceiling fans
Window fans Dehumidifier Humidifier (central/portable)
Steam vaporizer Cool mist vaporizer Central air cleaner Room air cleaner

How many house plants are in the home? _____

How many arrangements of dried flowers are there in the home? _____

Where does mildew or mold (usually black) tend to appear? **Circle any that apply**

Have never seen any Bathroom grout Basement Bathroom shower curtain
Closets Elsewhere in the bathroom Laundry area
Other rooms _____

Have you ever seen any cockroaches in your home? **YES NO**

Do you have any pets in your home? **Please circle all that apply** and indicate how many you have, and how long you have had the pet in your home.

Pet	How many	How long	Hours/day spent in the home
Cats			
Dogs			
Birds			
Hamsters			
Guinea pigs			
Gerbils			
Rats			
Mice			
Rabbits			

Other animal exposure (indoor or outdoor):

What type of pillow is used? **Circle the one best answer.**

Foam Dacron Feather Other synthetic

Is the pillow encased in a plastic/special dust mite protective material? **YES NO**

Is the mattress encased in a plastic/special dust mite protective material? **YES NO**

Are the box springs encased in a plastic/ special dust mite protective material? **YES NO**

OCCUPATIONAL EXPOSURE
(Complete only if your symptoms are related to work exposure)

Employers name: _____ Job title: _____

Date job began: _____ Date job ended: _____ Duration: _____

Industrial process: _____

Describe job activity

List materials used:

Estimate of intensity of exposure: SLIGHT MODERATE GREAT

Explain: _____

Was respiratory protection used? All the time Sometimes Rarely Never

List materials used by adjacent workers:

Estimate of ventilation/exhaust status Good Fair Poor

Explain: _____

Part-time jobs/ hobbies: YES NO

Explain: _____

CLINICAL INFORMATION

Any symptoms related to above? YES NO

Explain: _____

Time interval between job began and symptoms developed: _____

Relationship between work and symptoms? YES NO

Explain: _____

Time off work due to illness: YES NO

Number of days off: _____

Explain: _____

Other workers affected? YES NO

Explain: _____

Exams before employment and / or while working? YES NO

Explain: _____
