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

MINOR PATIENT REGISTRATION

Child's Full Name_____DOB_____Male/Female
Address_____City/State/Zip_____
Home Phone _____Pharmacy of Choice_____

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_____

Biological Mother/ Legal Guardian's Name_____DOB_____
Social Security #_____Phone #_____
Employer_____Employer Phone_____

Biological Father/ Legal Guardian's Name_____DOB_____
Social Security #_____Phone #_____
Employer_____Employer Phone_____

Primary care 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 my child is 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 my child and the expressed or implied instruction of my child's provider. I understand that any services furnished to my child outside of the scope of any instruction, express or implied, of my child's 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 child's 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 child's current treatment plan is complete or in one year from the signed date below.

_____ _____

Signature of Parent/Legal Guardian **Date**

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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 automatically be 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 your child 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:

_____ **DATE:** _____
Signature of Parent/Legal Guardian

_____ **DATE:** _____
Printed Name of Parent/Legal Guardian

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Prescription Consent

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

_____ _____

Signature of Parent/Legal Guardian **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.

_____Date_____

Signature of Parent or Legal Guardian

Parent or Legal Guardian's e-mail address_____

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Contact Consent

With consent, Allergy and Asthma Center of Montana, and/or representatives thereof may call my home or other designated location and may leave messages on a voicemail or in person in reference to any items that assist our office in carrying out treatment payment options which may include but are not limited to – procedures done during visit and diagnosis's used for billing purposes, insurance items including denial reasons, and balance of account.

Home/Cell Phone_____Work phone_____

- ☐ OK to leave a detailed message
- ☐ OK to leave detailed message with person
- ☐ OK to fax to this number_____
- ☐ Leave message with call back number only
- ☐ OK to leave message with call back number only
- ☐ OK to leave message with detailed information at work #

Written/Electronic Communications

- ☐ OK to mail to my home address
- ☐ OK to mail to my work office
- ☐ OK to send via my request to the following email_____

I acknowledge that this information will only be sent upon request and is not guaranteed to be sent securely._____
Initials

Persons that are **ABSOLUTELY NOT** to have my child's PHI

_____
_____
_____

Persons who **ARE ABLE** to discuss my child'sPHI

_____
_____
_____

By signing this form, I am consenting to Allergy and Asthma Center of Montana, and/or representatives to use and disclose my PHI to carry out treatment Payment Options. I may revoke my consent in writing except in the extent that the practice has already made disclosures in reliance upon my prior consent. This form will remain in effect until otherwise noted.

_____

Signature of Parent/Legal Guardian **Date**

_____

Printed Name of Parent/Legal Guardian

Allergy and Asthma Center of Montana
401 15th Avenue South, Suite 104
Great Falls, MT 59405

Elaine Barbieri, M.D.

NEW PATIENT HISTORY (Minor)

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 child's conditions.

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 child's allergic nose, eye, throat or ear symptoms:

Nasal itching	Sneezing	Post nasal drip	Hoarse voice
Nasal congestion	Nasal drainage	Sore throat	Throat itching
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 the symptoms occur (# of times per day, week, etc.,)

Are your child's 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)**

___At home	___At school	___At work
___Indoors	___Out doors	___Other Location_____

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

___Fresh cut grass	___High pollution days
___Dust	___Air conditioning
___Damp areas	___Smoke
___Entering a basement	___Cats
___House plants	___Dogs
___Barns/hay	___Other animals_____
___Wet weather	___Soap
___Dry weather	___Perfumes
___Wind	___Paint fumes
___Hot day	___Chemical odors
___Cold day	___News papers
___Weather change	___Other strong odors_____

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

Medication	**Result**

Has your child ever been evaluated by an allergist? (Circle one) **YES** **NO**
If YES, who was the previous allergist?_____
Have your child 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.

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

Has your child 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**

Has your child been diagnosed with asthma? **YES** **NO**
If yes, how often does your child use your rescue medicine (for example Albuterol)?_____

Does your child 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 the 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 child's 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_____		

DOES YOUR CHILD 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

Has your child ever had any of the following?:

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

Has your child ever had hives (urticaria), welts or problems with swelling of the lips, tongue, throat, hands or feet?

YES **NO** If YES, please describe:

_____

_____

_____

Has your child had any reactions after an insect bite or bee, wasp, yellow jacket, hornet or fire ant sting?

YES **NO** If YES, please describe:

_____

_____

_____

Has your child ever had problems after exposure to latex (gloves, balloons, rubber products, condoms, etc.)?

YES **NO** If YES, please describe:

_____

_____

_____

Does your child have a history of eczema or atopic dermatitis?

YES **NO** If YES, please describe the location of the rash and what treatment has been tried.

_____

_____

Has your child ever had contact dermatitis? (A rash after something touches the skin, such as certain metals or poison ivy)
YES NO If YES, please describe.

_____
_____
_____

Has your child ever had a reaction after an immunization/vaccine?
YES NO If YES, please describe._____
_____

PAST MEDICAL HISTORY

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

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

Has your child ever been on a ventilator (life support breathing machine) **YES NO**
If YES, for what and when?_____

Does your child have other conditions requiring regular medical attention?

Problem	**Year**

PAST SURGICAL HISTORY
List all surgeries since birth

Surgery

Has your child ever received immunizations for the following:
Influenza? **YES** **NO** Year immunized?_____
Pneumonia? **YES** **NO** Year immunized?_____

Has your child ever been exposed to anyone that you know who had TB? **YES** **NO**
Has your child ever had a **positive** TB skin test? **YES** **NO**

CIRCLE ANY AND ALL FINDINGS THAT APPLY TO YOUR CHILD VERY RECENTLY

GENERAL:
Fever Sweats Fatigue Recent appetite change Recent weight gain #_____pounds
Recent weight loss#_____pounds Formula feeding Breast feeding
SKIN:
Rash Rash in the sun Sensitive or itchy skin Hair loss Mole change
BLOOD:
Bleeding easily Bruise easily Swollen glands
ENDOCRINE / METABOLIC:
Frequent urination Frequent drinking Cold intolerance Heat intolerance Chronic steroid therapy
EYE:
Light sensitivity Blurred vision Diminished vision Vision loss Eye irritation
EAR /NOSE / THROAT:
Snoring Mouth/tongue sores Change in voice Nose bleeds
Hearing loss Ringing in ears Sinus pain
CARDIOVASCULAR:
Fainting Chest pain Leg swelling Palpitations Shortness of breath lying flat

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
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

YOUR CHILD'S SOCIAL HISTORY AND HABITS

Has your child ever used any of the following?

- Cigarettes _____ packs/day _____# of years.
- Pipe _____hours/day _____# of years.
- Cigars _____number/day_____# of years.
- Chewing tobacco
- Snuff

Is your child currently smoking? **YES** **NO** If previous smoker, year quit?_____
Interested in stopping? **YES** **NO**

Has your child 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_____

Grade in school or state if in daycare/preschool: _____

Has the child ever lived outside of Montana? **YES** **NO**
If YES, where:_____when:_____
how long_____

FAMILY MEDICAL HISTORY
(check all that apply)

	Father	Mother	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 the physician better assess your child's condition. This portion will tell us about other possible areas which could be causing discomfort.

In what type of dwelling does your child live? Please **circle** your answer.

House Town house Condominium
Apartment Flat Mobile home

What is the age of the dwelling? _____years old

How long has your child lived there? _____years_____months

Circle the one best answer: The 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 that one if applicable.**

Natural gas Electric Wood Fuel oil

What type of heat system does the 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 are used in the home:

Central air conditioning Room air conditioning Swamp cooler Ceiling fans
Window fans Dehumidifier Humidifier (central or 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 the home? **YES** **NO**

Do you have any pets in the home? **Please circle all that apply** and indicate how many you have, and how long there has been a pet in the 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**

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	Consultation Reports	Films
ALL Laboratory tests information	Progress Notes	Other_____
Radiology Reports	Discharge Summary _____	

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_____

_____Date:_____

(Signature/name of patient and/or patient representative)

If signed by other than patient, indicate relationship: _____

Signature of Physician: _____ Witness:_____ Date: _____