

Family Asthma & Allergy Center

730 Woodside Rd
Redwood City CA 94061
(650) 368-8800
asthma-allergy-ca.com

Welcome

All of us at the Family Asthma and Allergy Center would like to welcome you as a new patient to our office. Please read the Office Policies Brochure, fill in all six pages of the New Patient Registration & Medical History Form, and bring it with you on your first visit. If you have received this packet in mail and prefer to fill the form on a computer, you'll find it on the New Patient Page of our website: asthma-allergy-ca.com. Please print the filled form and bring it with you*.

You will need to stop taking any medications that contain antihistamines [such as Claritin, Benadryl, Clarinex, Zyrtec etc.] for a minimum of five days prior to your visit. If your appointment is less than five days away, or you cannot stop the Antihistamines due to severe symptoms, or you are not sure whether the medications you are taking contain an Antihistamine**, please call us. You must not stop any other medications you are on that do not contain antihistamines.

Please note that a new patient office visit can take up to three hours depending on the tests you may need.

If your insurance requires referral to see a specialist please ensure it is obtained prior to your visit date. If you need help with that or have questions about any other aspect of your visit please feel free to call us at **650-368-8800**.

We look forward to serving you.

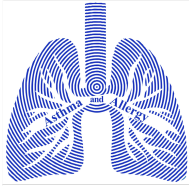
Sincerely yours,

Family Asthma and Allergy Center

*Besides the completed forms, please bring your Govt. issued photo ID (of the responsible person if other than the patient), health insurance and prescription cards, bottles of current medications if you are on more than two or three, and any referral documents or test reports your doctor may have given you.

**Many prescription and over the counter medications for cough, colds, allergies, sinus, sleep, mental health, vertigo, motion sickness, nose sprays, eye drops etc. contain antihistamines.

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What gender were you assigned at birth?

Patient's Name _____ Age _____ Birthdate _____ Male Female Other _____
Race/Ethnicity: Caucasian African-American Asian-American Hispanic Native American Other: _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ S.S# _____
Employer _____ Work Phone _____ Email: _____
Marital Status: Single Married Widowed Divorced Separated Student? Yes No
Spouse's Name _____ Spouse's Employer: _____
Spouse's Work Phone _____ Spouse's Work Address: _____
Are any family members patients here? No Yes If yes, who? _____
Name and address of a close relative not living with you: Name _____ Address _____
Home Phone _____

IF PATIENT IS A MINOR:

Mother's Name _____ Employer _____ WorkPhone _____ Cell _____
Father's Name _____ Employer _____ Work Phone _____ Cell _____
Legal Guardianship: Parents Mother Only Father Only Other: _____

REFERRING PHYSICIAN / PCP INFORMATION:

Doctor who referred for consultation : _____ Tel No. _____ Location: _____
Patient's Primary Care Physician: _____ Tel No. _____ Location: _____

HOW DID YOU HEAR ABOUT US?

Google Yelp Family/Friend Other: _____

PRESCRIPTION CARD INFORMATION:

Company Name _____ **Card I.D. No.** _____ **Your Pharmacy Name:** _____
1st _____
2nd _____ **Location:** _____ **Tel No:** _____

HEALTH INSURANCE: (You MUST bring your insurance cards with you)

1st Company Name: _____ Policy No. _____ Eff Dates: from _____ to _____
Policyholder Name & D.O.B. _____ SS# _____ Rel to Patient: _____
Address: _____ Home # _____ Work# _____ Cell #: _____
2nd Company Name: _____ Policy No. _____ Eff Dates: from _____ to _____
Policyholder Name & D.O.B. _____ SS# _____ Rel to Patient: _____
Address: _____ Home # _____ Work# _____ Cell #: _____

Does your insurance require referral or pre-certification to see a specialist? no yes don't know

Is treatment of allergies covered by your Insurance? no yes don't know

How much is your deductible? \$_____. Is it yearly? half yearly? Is it per person? whole family?

Have you met your deductible for this year? no yes In which month does your deductible restart? _____

PAYMENT & BILLING POLICIES

For Medicare, Medicaid and insurance programs that list us as preferred provider, you are responsible only for the deductible and copayments, **which must be paid at check out time**. We will submit and follow up the insurance claims.

For all other insurance policies, the deductible, copayment and coinsurance **must be paid at check out time**. We will submit your insurance claim if you wish, but you must follow up with your insurance company. In all cases you are responsible for whole or any part of the bill not covered by insurance.

If you are unable to pay as above at check out time, **please call in advance or see the receptionist before you see the doctor** to make alternate arrangements.

We accept Visa / MC / Discover/American Express/Apple Pay.

CONSENTS:

With respect to the patient described on this form, for services performed by any medical provider at or on behalf of Family Asthma and Allergy Center, I agree and give my consent as follows: telephone,

1. To conduct medical tests and give medical treatment as per the provider's best judgment.
2. Use this form as authority to submit bills and receive payments from my Health Insurance Companies.
3. To release any or all information and to send medical reports to my Health Insurance Companies, the referring doctor, the primary doctor and any other doctor treating the patient and as described in the Privacy Notice I have received, read and reviewed.
4. To contact me by **telephone, email or text messages** and leave messages on answering machine for test results, missed appointments and appointment reminders at telephone numbers and email addresses given above.
5. To act as my agent in obtaining payment from my Health Insurance Companies.
6. To use a copy of this authorization in place of the original.
7. That I will abide by the above Payment & Billing Policies.
8. That I have read and will abide by the above Payment & Billing Policies of Family Asthma & Allergy Center.

I confirm that I have read and I understand the above statements. I affirm that all information given on these papers is true to the best of my knowledge and that I have legal authority to give these consents on behalf of myself / or (Patient Name) _____

Further, I confirm that I have received a copy of the Privacy Notice.

Signature of responsible person _____ Date: _____ Witness: _____

Address: _____ SS # _____ Driver's Lic No. _____

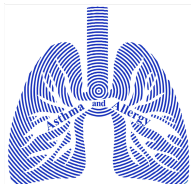
FOR OFFICE USE ONLY

Written consultation request / Fax response on file

Awaiting fax response

Privacy Notice given

_____ (initials & date)



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NEW PATIENT HISTORY

Pt. Name: _____

For what illness are you seeking treatment: D.O.B: _____

Check Major Symptoms: (If none, please **Check None**)

NOSE:	Itching Stiffness	Running Nosebleeds	Sneezing None
EYES:	Itching Redness	Watering Dark Circles	Swelling None
EARS:	Itching Fluid in Ears	Blocking Hearing Loss	Infections None
THROAT:	Itching Hoarseness	Voice Loss Post-Nasal Drip	Infections None
CHEST:	Coughing Shortness of Breath Green/Yellow Sputum	Wheezing Tightness Blood in Sputum	Smothering Infections None
HEADACHE:	Sinus Migraine	Facial Pain Other	Tension None
SKIN:	Hives General Itching	Eczema Rash	Swelling Text None
ABDOMEN:	Nausea Indigestion	Cramps Diarrhea	Vomiting None
GENERAL:	Fatigue Weight Loss	Feel Sick Poor Appetite	Infections None

Form Filled By: Patient

Parent/Guardian: (Enter Name & Relationship)

=====
Space below is For Provider Notes Only

Which of the above are most important to you?

Which of the above are currently bothering you? And for how long?

When did these problems occur for the first time in your life?

Are your symptoms: Constant? In attacks? Seasonal?
Recently getting worse? Explain:

Are you worse in: Jan. Feb. March April May June
 July Aug. Sept. Oct. Nov. Dec.

If attacks: How often do you have them?
 How long does each last?
 When did you have the last one?

Do you have symptoms all year round? N Y

Which is your worst season? Spring Summer Fall Winter
 All year round

Initials:MD

If seasonal or in attacks, are you completely clear of symptoms between spells? N Y Explain:

Pt. Name: _____

This space is for physician's notes

How many chest "colds" do you average per year? Explain:

Do you cough, wheeze, feel tight in the chest, or short of breath after exercise? n y Explain:

Do you cough, smother or wheeze at night? n y

Check any of the following that cause or increase your symptoms:

- | | | | |
|-------------|---------------------|-----------------|------------------|
| House dust | Flowers | Aspirin | Common Cold |
| Trees | Industrial Fumes | ACE Inhibitor | Air Conditioner |
| Feathers | Weather Change | Beta Blockers | Excitement |
| Weeds | Outdoors | Ibuprofen | Insect Stings |
| Animals | Food Odors | | Exertion |
| Grass | Paints, Varnishes | Beer/Wine | Laughing |
| Hay/Grain | Soaps/Detergents | Cocktail Shrimp | Dampness/Rain |
| Mold/Mildew | Cigarette Smoke | Potato Chips | Fatigue |
| | Cosmetics, perfumes | Salad bar | Cold Air |
| | Insecticides | Other foods | Menstrual Period |
| | | | Temp Change |

Are there any foods you cannot eat for reason other than taste? n y
If yes, which foods and why?

Have you had an unusual or severe reaction to insect stings? n y
Explain:

What treatment have you tried for this illness?

What helped the most?

Do you use nose spray? n y Name of spray?

Have you ever taken oral steroids (Prednisone, Medrol, etc.)? n y
Explain:

When was the last time you had a chest x-ray? Sinus x-ray? TB test?
What were the results?

Have you had allergy tests before? n y When?
By whom?

What were the main positive reactions?

Did you receive "allergy injections"? n y
Did they help? n y

If applicable, are you pregnant? n y BirthControl? n y

If child, is he/she up-to-date on immunizations? n y

Have you ever had pneumonia vaccine? n y Flu vaccine? n y

Is patient or any family member allergic to Penicillin or Cephalosporin? n y
Explain:

Initials: _____ MD

Pt. Name: _____

*This space is for
physician's notes*

ENVIRONMENTAL HISTORY

Are there feather pillows in the house? n y
Do you have plastic or dust mite covers on your mattress and pillows? n y

Carpeting in bedroom? Drapes?
Stuffed Animals? Type of Heating System?
Air Conditioning? Electronic Filter?
Do you have pets or other animals around the house? n y
What kind?
In or out of the house?

Is there any mold or mildew growth inside your house? n y
Explain:

Is there anything else around the house you suspect of causing
your symptoms? n y Explain:

Are there any special dusts or fumes where you work? n y
Explain:

Social History:

Never smoked or less than 100 cigarettes in lifetime

Current non-smoker: smoked for ____ years average ____ packs/day
quit ____ months/years ago

Current smoker: 1-3 cig/day ½ -1 pack/day 1-2 packs/day

Non-smoker but exposed to second-hand smoke at home or elsewhere?

Do you use smokeless tobacco? n y

Do you vape? n y Do you smoke marijuana or any other drug? n y

Alcohol: never/rare social light moderate heavy

PAST ILLNESSES: Has patient ever had any of the following?

Asthma	Nasal Polyps	Adenoidectomy
Hives	Bronchitis	Sinusitis
Tubes In Ears	Welts	Pneumonia
Ear Infections	Sinus Operation	Eczema
Hay Fever	Tonsillectomy	Nasal Surgery
Dermatitis	High Blood Pressure	Diabetes
Heart Disease	Tuberculosis	Peptic Ulcer
Liver Disease	Hiatal Hernia	Kidney Disease
Gastric Reflux	Leg Vein Thrombosis	Arthritis

Any other Illnesses: Explain:

FAMILY MEDICAL HISTORY (check if yes)

Have any BLOOD RELATIVES OF THE PATIENT had any of the following?

Bronchial Asthma	Hives	Migraine	Food Allergy
Emphysema	Hay Fever	Sinus	Eczema
Nasal Polyps	Bronchitis	Other Allergies	

Initials: _____ MD

Pt. Name: _____

*This space is for
physician's notes*

Please list all **Hospitalizations** with approximate dates and diagnosis.

Reason	Date
1.	
2.	
3.	
4.	

List all **Surgeries** with approximate dates and diagnosis.

Surgery	Date	Diagnosis
1.		
2.		
3.		
4.		

List all **Current Medical Problems** other than those you are coming to see us for, with approximate date and treatment you are taking.

Problem	Date of Diagnosis	Treatment
1.		
2.		
3.		
4.		

List all **Current Medications** you are taking, including supplements and herbals with approximate dates when started. If more than two, pl bring all current bottles with you.

For Allergic Rhinitis / Asthma:	Date Started
1.	
2.	
3.	
4.	

For other illness:	Date Started
1.	
2.	
3.	
4.	

Are there any **medications you are allergic to or cannot tolerate** for other reasons? n y
List all and explain:

1.	
2.	
3.	
4.	

Signature: MD

Date:

_____ Tarun M Kumar MD

_____ Anita Kallepalli MD

_____ Chandra Kumar MD