FamilyAsthma & 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.**	
1st	_____	_____	**Your Pharmacy Name:**_____
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	☐ Running	☐ Sneezing
	☐ Stuffiness	☐ Nosebleeds	☐ None
EYES:	☐ Itching	☐ Watering	☐ Swelling
	☐ Redness	☐ Dark Circles	☐ None
EARS:	☐ Itching	☐ Blocking	☐ Infections
	☐ Fluid in Ears	☐ Hearing Loss	☐ None
THROAT:	☐ Itching	☐ Voice Loss	☐ Infections
	☐ Hoarseness	☐ Post-Nasal Drip	☐ None
CHEST:	☐ Coughing	☐ Wheezing	☐ Smothering
	☐ Shortness of Breath	☐ Tightness	☐ Infections
	☐ Green/Yellow Sputum	☐ Blood in Sputum	☐ None
HEADACHE:	☐ Sinus	☐ Facial Pain	☐ Tension
	☐ Migraine	☐ Other	☐ None
SKIN:	☐ Hives	☐ Eczema	☐ Swelling
	☐ General Itching	☐ Rash	To ☐ None
ABDOMEN:	☐ Nausea	☐ Cramps	☐ Vomiting
	☐ Indigestion	☐ Diarrhea	☐ None
GENERAL:	☐ Fatigue	☐ Feel Sick	☐ Infections
	☐ Weight Loss	☐ Poor Appetite	☐ None

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

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

Form Filled By: Patient

Parent/Guardian: (Enter Name & Relationship)

_____

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Space below is For Provider Notes Only

Initials: . . . . . .MD

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 Polpys	☐ Bronchitis	☐ Other Allergies	

Initials:_____MD

Pt. Name:_____

This space is for physician's notes

Please list all H**ospitalizations** with approximate dates and diagnosis.

	Reason	Date
1.		
2.		
3.		
4.		

List all S**urgeries** with approximate dates and diagnosis.

	Surgery	Date	Diagnosis
1			
2.			
3.			
4.			

List all C**urrent 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 C**urrent 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

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