AHWATUKEE FOOTHILLS ALLERGY, ASTHMA & IMMUNOLOGY CLINIC
Allan M. Wachter, M.D., F.A.C.A.A.I., F.C.C.P.
16611 S. 40th Street - Suite 170, Phoenix, AZ 85048
Tel (480) 785-8000 - Fax (480) 705-8129
AhwatukeeAllergy.com

PATIENT INFORMATION

Name _____ Date of birth _____

Address _____ Apt #_____

City _____ State _____ Zip Code: _____

Phone _____ H Cell Wk Phone _____ H Cell Wk

Email Address _____

Social Security # _____ Marital Status _____ Gender/Sex_____

Emergency Contact: _____ Phone _____ Relationship to PT _____

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip Code: _____

Work Phone: _____ Full Time / Part Time / Retired

Referred by _____ Phone # _____

PCP _____ Cross Streets _____ Phone _____

Pharmacy _____ Cross Streets _____ Phone _____

PRIMARY INSURANCE INFORMATION

Insurance name: _____ HMO – PPO – POS – OTHER

Name of Insured: _____ DOB _____ Relationship to PT _____

Member ID# _____ Group # _____ Effective Date _____

SECONDARY INSURANCE INFORMATION

Insurance name: _____ HMO – PPO – POS – OTHER

Name of Insured: _____ DOB _____ Relationship to PT _____

Member ID# _____ Group # _____ Effective Date _____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. If my account is referred to collections, I agree to pay reasonable collection expenses including attorney fees. In the event that I am entitled to health insurance or other benefits available to cover the costs of my treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. All copays are due at time of service.

This office may release records pertaining to my treatment including those that relate to communicable diseases to my insurance company or other third parties responsible for payment of my medical charges.

Signed Patient/Parent/Guardian: _____ Date: _____

I attest the above information is accurate and current

Signed Patient/Parent/Guardian: _____ Date: _____

Signed Patient/Parent/Guardian: _____ Date: _____

Signed Patient/Parent/Guardian: _____ Date: _____

Signed Patient/Parent/Guardian: _____ Date: _____

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ALLERGY QUESTIONNAIRE

Date today:_____

Name of Patient: _____ Age: _____ Referred by: _____

Patient's Address: _____ Home phone: _____

Answer questions for the patient (yourself - or your child if he/she is the patient).

1. **SYMPTOMS:** (Circle those below that the patient has)

NOSE:	**EYES:**	**EARS:**	**THROAT:**	**CHEST:**	**SKIN:**
sneezing	itching	itching	sore	cough	itching
itching	burning	fullness	itching	breathlessness	hives
stuffiness	swelling	popping	swelling	wheezing	rash
mouth breathing	bloodshot	hearing loss	post-nasal	sputum (color _____)	
discharge (color _____)		discharge		discharge	

LIST OTHER SYMPTOMS (Headache, etc.) _____

_____

2. How long has the patient had "allergy" symptoms? _____

3. Symptoms or problems are: ( ) same all year round

or ( ) worse in these months circles below

Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

4. Is patient affected by:

Stress: ( ) No ( ) Yes If "yes" is stress ( ) emotional ( ) work related

( ) other _____

Running or other exercise: ( ) No ( ) Yes _____

Infections (colds, etc): ( ) No ( ) Yes _____

5. Physical agents: Does the patient have worse symptoms after exposure to the following?

Heat	( ) Yes	( ) No	Dampness	( ) Yes	( ) No
Cold	( ) Yes	( ) No	Wind	( ) Yes	( ) No
Drafts	( ) Yes	( ) No	Air Conditioning	( ) Yes	( ) No
Sunlight	( ) Yes	( ) No	Evaporative Cooler	( ) Yes	( ) No
Weather Changes	( ) Yes	( ) No	Heater	( ) Yes	( ) No

6. Specific Exposures: Check the exposures below which apply to the patient and make the symptoms worse.

( ) Dusting or sweeping household dust
( ) Working or playing in dirt
( ) Mowing lawn
( ) Being in damp or musty places
( ) Being near pets or other animals
( ) In barns or stables
( ) Preparing food
( ) In garden

Is there a place in the house or elsewhere where the patient is definitely better or definitely worse: ( ) No ( ) Yes

If yes, describe: _____

_____

Name: _____

Does exposure to any of the following bring on symptoms? (Circle if yes)

Cosmetics	Chemicals	Lint
Perfumes	Insecticides	Wool
Hair Spray	Paint, Varnish	Smoke

Do any of the following foods cause symptoms? (Circle if yes)

Eggs	Peanuts	Citrus Fruits
Milk	Nuts	Corn
Wheat	Chocolate	Berries
Fish	Tomatoes	Other foods: _____

7. The patient has lived in Southern Arizona for how long? _____

Has the patient had allergy tests? ( ) Yes ( ) No

If yes, when? _____ Where? _____

Were they skin tests? ( ) Yes ( ) No or other type of tests (explain) _____

_____

8. Treatment: (medicines you take or have taken for the current problem)

	Medicines Taken:	Was Medicine Effective?	Side Effects:
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____

Allergy shots taken in past? ( ) Yes ( ) No

Other medicines the patient is currently taking: _____

_____

9. Associated symptoms: Check if the patient has had:

( ) Hives	( ) Eczema	( ) Chronic diarrhea	( ) Sinus
( ) Migraine	( ) Recurrent pneumonias	( ) Nasal polyps	

10. Family History: Are there allergy conditions in:

( ) Brothers or Sisters (list) _____

( ) Parents (list) _____

( ) Grandparents (list) _____

11. Does the patient have a history of:

( ) diabetes ( ) high blood pressure ( ) heart disease ( ) valley fever

( ) other illness _____

Hospitalizations or Operations: ( ) Yes ( ) No

If yes, when, and what for: _____

12. Has the patient ever had any reaction to any of the following? (Circle if yes)

Aspirin	Vitamins	Hormones
Nose drops	Nerve medicines	Antitoxins
Laxatives	Sulfa drugs	Immunizations
Sedatives	Penicillin	Antihistamines
Pain medicines	Mycins	Decongestants
Cortisone or similar drugs		

Name: _____

Other medicine reactions? _____

_____

13. Occupation:

Husband _____

Wife _____

Child _____

14. Facts about your home:

Location: ( ) City ( ) Rural Circle section of town (NW SW NE SE)

Age of home ( ) less than 5 years ( ) 5-15 years ( ) over 15 years old

Heating system: ( ) Gas ( ) Electric ( ) Space Heater

Cooling system: ( ) Evaporative (swamp) cooler ( ) Air conditioning

Construction: ( ) Frame ( ) Adobe ( ) Stucco ( ) Block

Fireplace: ( ) Yes ( ) No

Number of pets in house: _____ Cats _____ Dogs _____ Birds _____ Others

Outside pets: _____

Houseplants: ( ) less than 20 ( ) more than 20

Are there smokers in the house? ( ) Yes ( ) No

Bedroom of patient:

( ) Sleeps alone ( ) Shares bedroom

Mattress: ( ) Regular inner spring ( ) Foam ( ) Waterbed

Pillow is: ( ) Feather or down ( ) Foam ( ) Synthetic (dacron or polyester)

Bedding is ( ) Comforters ( ) Quilts ( ) Wool blankets ( ) Other _____

Books in Bedroom? ( ) Yes ( ) No

Landscape:

( ) Desert Type ( ) Non-desert landscape

Grass: ( ) No ( ) Yes If yes, is grass ( ) Bermuda or ( ) Tiff green

Trees: ( ) Mulberry ( ) Olive ( ) Mesquite ( ) Cottonwood ( ) Other _____

Weeds in yard or nearby: ( ) No ( ) Yes

15. Have you ever had a reaction to an insect sting or bite?

If yes, when? _____

Type of reaction: _____

Treatment: _____

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HEALTH QUESTIONNAIRE

Patient Name: _____ MR#_____ Date _____

This questionnaire will help your physician obtain a large amount of information while still being able to focus on your most important problems. Please answer all questions as best you can. If you are uncertain about a question your physician will help you. All answers will be kept confidential.

Sex _____ Age _____ Date of Birth _____

Current and Past Medical Problems (For example: anemia, asthma, arthritis, bleeding problems, colitis, cancer, high cholesterol, diabetes, hepatitis, high blood pressure, heart murmur, heart attack, depression, epilepsy, glaucoma, kidney problems, migraines, HIV, thyroid, pneumonia, Valley fever)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Operations (For example: tonsillectomy, appendix, gallbladder, hernia, caesarean section, vasectomy, breast implants, heart bypass, or valve operation, hysterectomy)

1. _____ Date _____ 4. _____ Date _____
2. _____ Date _____ 5. _____ Date _____
3. _____ Date _____ 6. _____ Date _____

Medications (List all the medications you currently take including prescriptions, cold medications, aspirin, vitamins, herbal remedies, eye drops, and birth control pills. Please list all medication dosages and frequency taken)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Allergies to Medications (List all medications that you cannot take, or have had a reaction to)

Medication:	Reaction:	Medication:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ MR # _____

Social History

Marital Status _____ Occupation _____

Highest level of education _____ Hobbies _____

1. Do you smoke cigarettes? ❑ Yes ❑ No How many per day? _____
2. Have you smoked in the past? ❑ Yes ❑ No How many years? _____
3. Do you drink alcohol ❑ Yes ❑ No How many drinks per week? _____
4. Do you use caffeine ❑ Yes ❑ No How much? _____
5. Have you used illegal drugs? ❑ Yes ❑ No List type _____
6. Do you exercise? ❑Yes ❑ No

   What type? _____ How often?_____

7. How much do you weigh? _____ 5 years ago? _____ 10 years ago? _____
8. Do you have any risk factors for AIDS or HIV infection? _____

Health Maintenance

Please list date (year) of the last time you had any of the procedures.

_____ Complete Physical _____ Cholesterol Screen _____ Sigmoidoscopy

_____ Pap Smear _____Mammogram _____ Prostate Check

_____ Chest X-ray _____EKG _____Treadmill

_____ Tetanus Shot _____Flu Shot _____Pneumonia Vaccine

_____ Hepatitis B Vaccine _____Hepatitis A vaccine

_____ Measles, mumps, rubella vaccine

Gynecological History

_____ Last menstrual period _____ Age of menopause

_____ Number of pregnancies _____ Number of children

_____ Number of miscarriages _____ Number of abortions

Type of birth control _____

Family Health History (Blood relatives)

List family members who have had any of the medical problems: Cancer, heart attack, high cholesterol, high blood pressure, diabetes, osteoporosis, sickle cell anemia, kidney diseases, asthma, thyroid or any other common illness.

Illness:	Family member(s):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PATIENT FINANCIAL POLICIES AND AGREEMENT FORM

Please read this form **CAREFULLY**, if you have any questions or concerns or need help understanding any of the information about any area please let us know. By signing this form you agree to the terms mentioned in each area. **EACH** one **MUST** be signed, even if it does not apply to you at the present time, you must be aware of the policy.

Ahwatukee Allergy is committed to providing you the most reliable healthcare, as well as facilitating the lowest health insurance costs. To ensure that you continue to receive the best healthcare possible and to keep the billing costs to a minimum we need your help in the following ways:

- You MUST always present your most current health insurance card for each appointment.
  - This will be required in order to keep your appointment and will be asked for upon arrival, if you do not have it, you will have to reschedule and you will be billed for the appointment.
- You MUST notify us of any changes with insurance, address, phone number, etc…
- You MUST pay your co-pay, deductible, or self-pay at the time of service.
  - Your co-pay is a contract agreement between you and your insurance and cannot be waived.

Patient Signature _____ Date _____

<u>Insurance</u>

It is the responsibility of the patient/guardian to know the benefits and eligibility as pertaining to a specialist. Co-pays may be different from your PCP, if it is not stated on your card, please call your insurance to find out.

*If you are trying to find your co-pay for allergy shots, there are a few ways to search:

- Go online and search under allergy shots, allergy injections, or specialty.
- When calling the insurance, let them know it is NOT a doctor's visit.

Patient Signature _____ Date _____

No Insurance

If your insurance has termed, or you do not have insurance, your payment must be collected at the time of service. We do discount self-pay services. It is your responsibility to know whether your insurance is termed or not, we suggest before an appoinment that you call and verify your eligibility; insurance coverage can change minute to minute.

Patient Signature _____ Date _____

Referrals

If you have an HMO plan or a POS, YOU may be required to provide a referral from your PCP. We must have this at the time of appointment or you will be charged for the total costs.

Patient Signature _____ Date _____

Canceled, Rescheduled No Show and Late Appointments

If you are unable to keep an appointment we are more that happy to reschedule for you. If you need to cancel it is very important that you give us 24 hours notice, this will allow us to offer your time slot to someone in need of an appointment. If you no show an appointment, you may be billed $25 for that appointment, this will not be billed to insurance but will be billed directly to you. This charge will need to be collected in order to schedule another appointment. If you are more than 20 minutes late you will have to reschedule for another date.

Patient Signature _____ Date _____

Ancillary Fees

Services conducted outside of your appointment may be billed to your account. This could include but not be limited to phone calls regarding your care, phone calls on your behalf, letters or completion of forms. Ancillary fees are not reimbursed by your insurace, this balance would be due from you.

Patient Signature _____ Date _____

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If you are unable to keep your scheduled appoinment, please call at least **24 hours** in advance to let us know.

This is a courtesy to our staff and physician, as well as other patients who may be in need of an appointment.

It is now the policy of this office to assess a “no show” fee for missed appointments.

Follow up visit: $25.00

New Patient visit: $50.00

This fee will not be billed to your insurance, it will be billed directly to you.

New Patients please arrive ten to fifteen minutes prior to your appointment with your packet already filled out.

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be madde by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

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MEDICAL RECORDS RELEASE FORM

PATIENT NAME: _____ DOB: _____

I hereby authorize:

Physician's name: _____

Address: _____

_____

Phone: _____ Fax: _____

To disclose any and all health information, including copies of medical records for the purpose of continuing medical care to the following:

Physician's name: _____

Address: _____

_____

Phone: _____ Fax: _____

_____ ALL RECORDS

_____ LABS/PATHOLOGY

_____ X-RAY/CT/MRI OF THE _____

_____ OTHER (DESCRIBE) _____

_____

Your agreement will be requested in advance for any copying or mailing fees that the practice incurs to fulfill your request. This practice has the right to deny access, in whole or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings, were provided by a non-provider under promise of confidentiality concerning their identity, or could place in danger your life or the lives of others.

Signature: _____ Date: _____

Relationship to patient: _____

Preparing for an Allergy Evaluation

IMPORTANT Information for your upcoming visit:

Please complete your allergy questionnaire and bring a list or bag of your medications, bottles of allergy solutions and copies of medical records to your office visit.

Preparation for Allergy Testing:

Antihistamines and decongestants can interfere with skin testing by blocking the allergic response. In order for us to give you accurate test results please stop all prescription and over the counter **(OTC)** antihistamines and decongestants **2-3 days PRIOR** to your appointment. These medications include :

- Cough and cold remedies
- Motion sickness medications
- Sleep aids

Some antihistamines are longer-acting and should be stopped **7 days before** allergy testing :

- Cetirizine / Zyrtec
- Cortisone cream to the arms or back
- Desloratadine / Clarinex
- Doxepin / Sinequan
- Fexofenadine / Allegra
- Loratadine / Claritin / Alavert / or generic
- Levocetirizine / Xyzal

Stop **3 days before** the test

- Azelastine HCL / Asteline / Astepro
- Hydroxyzine / Atarax / Vistaril
- Olopatadine / Patanase
- Sudafed
- Tussinex

Stop **2 days before** the test

- Actifed
- Advil Allergy / Sinus
- Chlorpheniramine / Chlortrimetron
- Cyproheptadine / Periactin
- Contac
- DayQuil
- Deconamine

Stop **2 days before** the test :

- Dimetapp
- Diphenhydramine / Benadryl
- Drixoral
- Duravent DA
- Dura-tap
- Zantac / Rantitidine

All other cough / cold medicines should be stopped **2 days** before the test.

Stop **1 day** before the test **if permitted by your primary care physician:**

- Amitriptyline / Elavil
- Desipramine / Norpramin
- Nortriptyline / Pamelor
- Imipramine / Tofranil
- Trazodone / Desyril

If you are on any **beta-blockers** (Tenormin / Atenolol, Lopressor/Toprol-XL/Metoprolol, Corgard/Nadolol, Trandate/Labetalol, Inderal/Propranolol, or Normodyne), please contact our office prior to your appointment for further instruction.

DO NOT STOP ANY ASTHMA MEDICATIONS or nasal steroids before your visit. Do not stop Singulair. Do not stop any inhalers. **If possible. do not take your albuterol inhaler** (ProAir, Ventolin, Proventil, Xopenex) **4-6 hours** before your visit. **Do not stop any blood pressure medications, diabetes medications or eye drops** unless this has been arranged with your primary care physician in advance.

Most drugs do not interfere with testing, but make certain that your physician and nurse know about every drug you are taking (bring a list or the drugs if necessary).
Thank you for not wearing perfumes or aftershaves on the day of your appointment as it may be irritating to another patient with respiratory symptoms.
Please **do not bring nut** containing foods into this office.
Please allow a minimum of 2 hours for this appointment.
We appreciate you choosing our office for your allergy care.