Boulder Valley Asthma and Allergy

Account Number:________

Name:____________________ Date:________

Reason for Appointment:____________________

Informant: ☐ Patient ☐ Parent ☐ Other:________

Have you had any previous allergy evaluations? ☐ Yes ☐ No

Current Medications: ☐ None ☐ See Attached

Prescription (include dose and frequency)	Over the Counter/Vitamins/Supplements

Chronic or Past Medical Problems: ☐ None

☐ Asthma	☐ GERD	☐ Osteoporosis
☐ AIDS/HIV	☐ Glaucoma	☐ Other Autoimmune Disease
☐ **Angioedema/Anaphylaxis**	☐ **Hay Fever, Nasal Allergies**	☐ Other Heart Disease
☐ Barrett's Esophagitis	☐ Hepatitis- Type:	☐ Other Liver Disease
☐ Blood Clotting Disorder	☐ High Blood Pressure	☐ Other Lung Disease
☐ Cancer- Type:	☐ High Cholesterol/Triglycerides	☐ Psoriasis
☐ Cataracts	☐ **Hives**	☐ Rheumatoid Arthritis
☐ COPD	☐ **Immunodeficiency**	☐ Sarcoidosis
☐ Crohn's Disease	☐ Insect Sting Allergy	☐ Seizures/Epilepsy
☐ Diabetes- Type:	☐ Kidney Disease	☐ **Sinus Problems**
☐ **Eczema**	☐ Latex Allergy	☐ Stroke
☐ Emphysema	☐ Lupus	☐ Thyroid Disease
☐ Eosinophilic Esophagitis	☐ Migraine Headaches	☐ Ulcerative Colitis
☐ **Food Allergy**	☐ Osteoarthritis	
List Any Other Serious or Chronic Medical Problems:		

Drug Allergies/Adverse Reactions: ☐ No Known Drug Allergies ☐ See Attached

Medication:	Reaction:

Past Surgical History/Hospitalizations (except for normal births): ☐ None

	Other Surgeries/Hospitalizations:
☐ Adenoidectomy Year:	Year:
☐ Nasal/Sinus Surgery Year:	Year:
☐ PE Tubes Year:	Year:
☐ Tonsillectomy Year:	Year:

Family History:

☐ Family History Unknown

	Nasal Allergy	Asthma	Food Allergy	Skin Allergy	Other Conditions
Mother ☐ Living ☐ Deceased					
Father ☐ Living ☐ Deceased					
Brother # Living______ # Deceased______					
Sister # Living______ # Deceased______					
Grandmother (maternal) ☐ Living ☐ Deceased					
Grandmother (paternal) ☐ Living ☐ Deceased					
Grandfather (maternal) ☐ Living ☐ Deceased					
Grandfather (paternal) ☐ Living ☐ Deceased					
Aunt ☐ Living ☐ Deceased					
Uncle ☐ Living ☐ Deceased					

Social History:

Pets:	☐ Cats #_____ ☐ Dogs #_____ ☐ Other________________ ☐ None
Second-Hand Smoke Exposure:	☐ Yes ☐ No ☐ Occasional
Tobacco/Substance Use: (complete if age 13 or over)	
Cigarettes:	☐ Never ☐ Former Age started______ Age stopped_____ Average # cigs per day_____ ☐ Current Age started______ Average # cigs per day_____
E-cigarettes:	☐ Yes ☐ No How often?________________
Vape:	☐ Yes ☐ No How often?________________ What do you vape?________________
Marijuana:	☐ Yes ☐ No ☐ Occasional
Other Tobacco:	Describe:
Alcohol:	☐ None ☐ Former ☐ Current Average # of drinks per day_____ per week_____ ☐ Only Occasional
Other Substance Use:	Describe:

Enviromental History:

Heating System:	☐ Forced Air ☐ Hot Water Baseboard ☐ Radiant Heat ☐ Wood/Pellet Stove
Air Conditioning:	☐ None ☐ Central ☐ Window/Wall AC ☐ Evaporative Cooler
Home:	☐ House ☐ Townhouse ☐ Condo ☐ Apartment ☐ Mobile Home ☐ Dormitory
Years in Current Home:	
Age of Home:	
Years Lived in Colorado:	☐ Native ☐ _____ Months ☐ 1-5 Years ☐ Over 5 Years ☐ Over 10 Years ☐ Over 20 Years ☐ Does Not Live in CO
Down/Feather Bedding:	☐ None ☐ Pillows ☐ Comforter ☐ Mattress Topper
Mattress:	☐ Spring ☐ Foam/Latex ☐ Air/Water
Age of Mattress:	
Main Living Flooring:	☐ Carpet ☐ Wood/Tile ☐ Combination of Carpet and Wood/Tile
Bedroom Flooring	☐ Carpet ☐ Wood/Tile
Basement Flooring:	☐ Cement ☐ Subfloor ☐ Unfinished ☐ Carpet ☐ Wood/Tile ☐ Crawl Space
Wool Carpeting/Area Rugs:	☐ Yes ☐ No
Other Occupational/Home Exposures:	Describe:

Current or Recurrent Symptoms (please check all boxes that apply):

General/Constitutional:	☐ Fatigue ☐ Fever ☐ Sweats ☐ Weight Gain ☐ Weight Loss ☐ Change in Appetite
Opthomologic:	☐ Itching ☐ Redness ☐ Watering Eyes ☐ Dry Eyes ☐ Discharge
ENT:	☐ Ear Pain ☐ Ear Plugging ☐ Ringing in the Ears ☐ Recurrent Ear Infections ☐ PE Tubes ☐ Runny Nose ☐ Post Nasal Drainage ☐ Stuffiness ☐ Sneezing ☐ Nosebleeds ☐ Nasal Polyps ☐ Loss of Smell/Taste ☐ Snoring ☐ Sinus Pressure/Headaches ☐ Sore Throat ☐ Itchy Throat ☐ Hoarseness ☐ Frequent Thorat Clearing
Cardiovascular:	☐ Chest Pain ☐ Irregular Heartbeat ☐ Fainting ☐ Swelling in Hands/Feet ☐ Heart Murmur
Respiratory:	☐ Productive Cough ☐ Dry Cough ☐ Wheezing ☐ Chest Tightness ☐ Shortness of Breath ☐ Coughing and/or Wheezing with Exercise
Gastrointestinal:	☐ Bloating ☐ Food Allergy ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Heartburn ☐ Difficulty Swallowing
Genitourinary:	☐ Frequent Bladder Infections
For Women:	☐ Currently Pregnant ☐ Menopausal
For Men:	☐ Prostate Problems
Skin:	☐ Itching ☐ Eczema ☐ Hives ☐ Psoriasis ☐ Rash
Neurologic:	☐ Headache ☐ Seizures ☐ Sleep Disturbance
Musculoskeletal:	☐ Swollen Joints ☐ Painful Joints ☐ Muscle Pain ☐ Back Pain
Endocrine:	☐ Cold Intolerance ☐ Hair Loss ☐ Excessive Thirst ☐ Unexplained Weight Change
Psychiatric:	☐ Anxiety ☐ Depression ☐ Mood Disorder
Hemotology:	☐ Lymph Node Swelling ☐ Anemia
Allergy/Immunology:	☐ Allergy Swelling/Angioedema/Anaphylaxis ☐ Frequent Bronchitis/Pneumonia ☐ Frequent Sinusitis

BOULDER VALLEY ASTHMA AND ALLERGY

PATIENT INFORMATION

Account No:__________

Prefix:__________

Date Of Birth:___/____/____

Last Name: ______________________ Suffix : :__________ Gender: :__________

First Name: ______________________ MI:_____ SSN:____-_____-______

Previous Name:____________________ Preferred Name: __________________

Martial Status: __________________ Occupation:________________________________

Preferred Language:________________________________

Race:______________ Ethnicity:________________

Address Line 1: ____

Address Line 2: ____

City:____________ State:_____ Zip:_________ Country:________

Home Phone:(____)______-___________ Cell Phone: (___)______-_________

Work Phone:(____)______-__________ Ext:_____

Email:_____________________________________

Preferred Communication Method of Contact (Check all that apply)

Home Phone   Cell Phone   Work Phone   Email

Ok to Leave Voicemail?   YES   NO

Date of Last Appointment:_____/_____/______or New Patient

Responsible Party (If Same as above, leave blank)

Last Name:________________ First Name: ____________________ MI:____

Date of Birth: _____/_____/______ Gender:______________

Address:_____________________________City:___________ State:_____Zip:_________Country:____

Preferred Communication Method of Contact (Check all that apply)

Appointment Reminders   Notifications   Test Results

Home Phone: (____)______-_______Cell Phone: (____)______-_________Work Phone: (____)______-_______

Email: Ok to Leave Voicemail?   YES   NO

Emergency Contact Information

Name:__________________________ Phone:(____)______-_____________ Relation:____________________

Care Team

Primary Care Physician:__________________ Phone: (___)______-_______ Fax: (___)____-________

Referring Physician: __________________ Phone: (___)______-_______ Fax: (___)____-__________

Insurance

Primary Insurance Company____

Address:______________________________________ City:___________State:______ Zip:__________

ID Number:___________________________________ Group Number:_________________________

Insured Name:_________________________________ Insured Date of Birth: _____/_____/__________

Insured Employer: _____________________________ Relationship to Patient:____________________

Secondary Insurance Company: ____

Address:______________________________________ City:___________State:______ Zip:__________

ID Number:___________________________________ Group Number:_________________________

Insured Name:_________________________________ Insured Date of Birth: _____/_____/__________

Insured Employer: _____________________________ Relationship to Patient:____________________

Pharmacy

Primary Pharmacy Name:____

Address: _______________________________________ City:___________ State:_______ Zip:_______

Telephone Number: (_____)_____-__________ Fax Number: (_____)_____-__________

Secondary Pharmacy Name:____

Address: _______________________________________ City:___________ State:_______ Zip:_______

Telephone Number: (_____)_____-__________ Fax Number: (_____)_____-__________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Boulder Valley Asthma and Allergy Clinics, PC. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize BVAAC and/or my insurance company to release any and all information required to process my claims.

Patient/Responsible Party Signature___________________________ Date: _______________

BOULDER VALLEY ASTHMA AND ALLERGY

AUTHORIZATION FOR RELEASE OF INFORMATION

Acct#____________________

I do not give permission for BVAAC to communicate with anyone else regarding my care:__________(initial)

I hereby authorize Boulder Valley Asthma and Allergy Clinics, PC (BVAAC) to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available on our website www.denverallergy.com or it is available in our offices.

I give permission for BVAAC to contact me in the following ways. BVAAC is allowed to leave messages as indicated below. A detailed message could outline results, answer questions, give details about treatment, payments, and/or appointment reasons, etc. A short message would ask for a call back only. (You may check more than one box).

Cell Phone: ________________________________

Land Line:________________________________

Work Line:________________________________

Email Address: ________________________________

I give BVAAC permission to communicate with the following individuals regarding my care (list as many or as few as you wish):

Name:____________________ Phone:____________________Relationship:____________________
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

Name:____________________ Phone:____________________Relationship:____________________
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

Name:____________________ Phone:____________________Relationship:____________________
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

Name:____________________ Phone:____________________Relationship:____________________
Medical Information (test results, treatment, etc.) Financial Information (Billing, Patient Balances, etc.)

BOULDER VALLEY ASTHMA AND ALLERGY

AUTHORIZATION FOR RESEARCH RELEASE OF INFORMATION

Acct#________________

The physicians at Boulder Valley Asthma and Allergy Clinics, PC, participate in pharmaceutical/medical research studies. We believe that this is a valuable service as it not only allows us the ability to evaluate potentially new therapies for our patients, but also provides us with the opportunity to remain current in our chosen field of medical science. A study/research coordinator will be allowed to review my PHI to determine if I am a potential candidate for participation. The study/research coordinator will NOT release my name or other personal information other than that which directly pertains to the pharmaceutical/medical research study to any third party or outside agencies.

YES NO

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

Patient/Responsible Party Signature:____________________________Date:____________________

Patient Name (Printed)____________________________________ Date of Birth:_______________

BOULDER VALLEY ASTHMA AND ALLERGY

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Acct#________________

Additionally, I hereby acknowledge that I have received a copy of Boulder Valley Asthma and Allergy Clinics' Notice of Privacy Practices. This is available on our website www.denverallergy.com or may be requested in our office. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Patient/Responsible Party Signature:____________________________Date:____________________

Patient Name (Printed)____________________________________ Date of Birth:_______________

Office Use Only: Reason Acknowledgement could not be attained on ____________ (date)

BOULDER VALLEY ASTHMA AND ALLERGY

Financial Policy

Thank you for choosing Boulder Valley Asthma and Allergy Clinics, PC (BVAAC) for your allergy, asthma and immunology healthcare needs. We are committed to providing the very best medical care. We do our best to inform you of any allergy benefit information that we receive from your insurance carrier; however, it is ultimately your responsibility to pay for any charges you incur. The following is a statement of our Financial Policy, which you must read, agree to and sign prior to treatment. *If you have questions or concerns, please contact our billing office at 303-234-1067 opt. 3 prior to your appointment.*

- Know your insurance coverage, benefits and referral requirements: there are many insurance companies, all with several different plans, policies and benefits. **It is your responsibility to be aware of and understand your insurance benefits, coverage, exclusions, deductibles, co-insurance and referral requirements.**
- BVAAC accepts most major insurance plans; however, there may be plans which we are excluded from participating in. We recommend calling your insurance company to verify that we are in-network providers prior to your appointment. It is your responsibility to verify that BVAAC is a participating provider on your specific plan.
- We will bill your insurance company for your office visits, testing, allergy extracts, injections, etc. However, at the time of your appointment it is your responsibility to pay:
    - Any insurance copayment amount (as listed on your card). We are a specialist and charge the specialist copay.
    - Any amount subject to your deductible or co-insurance.
    - Any amount not covered by your insurance coverage.
- Failure to collect this amount at the time of service does not change your financial responsibility.
- Patients/Guardians are financially responsible for all charges, regardless of third-party guarantors.
    - In the case of a divorce situation, the adult accompanying the minor child is responsible for payment of services. Our office staff will not participate in any disputes, which may arise with respect to financial liability due to legal custody agreements.
- Self-pay patients must pay in full at the time of service, unless a satisfactory payment arrangement has been made with our billing office, prior to services being rendered.
- Any account balance is expected to be paid in full prior to new services being rendered.
- We accept cash, checks, Visa, Mastercard, and Discover. Payment may be made through our patient portal, over the phone by calling 303-234-1067 opt. 3, or by mail.
- Should it be necessary for BVAAC to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes (name, address, phone number, insurance coverage, etc.), you must inform this practice as soon as possible. Insurance denials or billing errors due to patient supplied information will result in the transfer of account balances to the patient's immediate financial responsibility.

Appointment Cancellation/No Show Policy/Tardy Policy

Boulder Valley Asthma and Allergy Clinics, PC (BVAAC) understands that there are times when you must miss an appointment due to an emergency or unforeseen circumstances. However, when you do not call to cancel your appointment, you may be preventing another patient from receiving much needed medical care. If you need to cancel your appointment to see a BVAAC physician, you must do so within 24 hours of the appointment or you will be charged a $50 cancellation fee. This fee will not be covered by your insurance. You need to speak directly with a BVAAC staff member to cancel an appointment and avoid the late cancellation charge.

We understand that delays can happen; however, we must try to keep other patients and physicians on time. If a patient arrives 15 minutes past their scheduled check in time, we will have to reschedule the appointment.

My signature below indicates that I have read and agree to BVAAC financial policy, appointment cancellation, no show and tardy policies. I understand that I am financially responsible for all charges. I understand that it is my responsibility to contact the office to reschedule and/or cancel my appointment.

Patient/Responsible Party Signature: ______________________________ Date: ____________

Patient Name (printed): ______________________________ Date of Birth: ____________