BOULDER VALLEY ASTHMA AND ALLERGY

PATIENT REGISTRATION FORM

Acct # _____

Patient Information

Legal First Name _____ M.I. _____ Last Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Work # _____

Birth Date _____/_____/_____ Social Security # _____ or Drivers License # _____

Gender: M / F **Marital Status:** Married Single Divorced Other **Preferred Language:** English Other _____

Ethnicity: Hispanic/Latino Non Hispanic/Latino **Race:** Caucasian African American Asian Other _____

Referred by _____ Primary Physician _____

Responsible Party

Legal First Name _____ M.I. _____ Last Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email _____

Birth Date _____/_____/_____ **Gender:** M / F

Social Security # _____ or Drivers License # _____

Employer _____ Work # _____

Insurance Information

Primary Insurance Company _____

Address _____
Street City State Zip

ID Number _____ Group Number _____

Insured Name _____ Insured DOB _____

Insured Employer _____ Relationship to Patient _____

Secondary Insurance Company _____

Address _____
Street City State Zip

ID Number _____ Group Number _____

Insured Name _____ Insured DOB _____

Insured Employer _____ Relationship to Patient _____

Financial Policy: I authorize the release of any information necessary to process claims. I request payment of benefits to Boulder Valley Asthma and Allergy Clinics, PC (BVAAC). I understand I am financially responsible for charges not covered by insurance.

If your plan has a co-payment, deductible and/or co-insurance you will be expected to pay your portion prior to receiving any service including an office visit and/or immunotherapy. If you are on a high deductible plan, you will be required to pay a minimum of 50% at the time of service until we verify that your deductible has been met or other arrangements have been made. **Boulder Valley Asthma and Allergy Clinics, PC accepts most major insurance plans however there may be plans which we are excluded from participating in. It is your responsibility to verify that BVAAC is a participating provider with your specific plan.** In the case of a divorce situation, the adult accompanying a minor patient 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. Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become 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.

I understand and agree that if my treatment at BVAAC requires a primary care physician referral, it is my responsibility to see that the referral is current and valid prior to receiving care at BVAAC. If no referral is present in advance, I agree to pay for charges at the time services are rendered. BVAAC accepts cash, checks, Visa, Mastercard and Discover for your convenience.

Patient/Responsible Party Signature _____ **Date** _____

Acct # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

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.

Patient authorizes communication with family/friends regarding your **care and test results.**

Name _____ Phone # _____

Name _____ Phone # _____

Patient authorizes communication with family/friends regarding your **account and billing.**

Name _____ Phone # _____

Patient authorizes communication with a primary care physician or other physician (first and last name):

1. _____ M.D.

2 _____ M.D.

Best way to contact you regarding messages, responses, test results etc.: ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Please select ONE contact method for appointment reminders, office closures or other appointment related messages: ☐ Phone call to primary # listed on account ☐ Text ☐ Email ☐ Secure Email (portal registration required)

1. May we leave a message on home voicemail?	☐ Yes	☐ No	☐ N/A
2. May we leave a message with whomever answers the home phone?	☐ Yes	☐ No	☐ N/A
3. May we call your work and leave a message with the person who answers the phone?	☐ Yes	☐ No	☐ N/A
4. May we leave a message on work voicemail?	☐ Yes	☐ No	☐ N/A
5. May we contact you via Email? Email Address:_____	☐ Yes	☐ No	☐ N/A
6. May we contact you via text message? #: _____ (Standard text or data usage rates may apply depending on your plan and/or carrier)	☐ Yes	☐ No	☐ N/A
7. May we send out your PHI to a third party such as a laboratory, insurance company or any other medical provider?	☐ Yes	☐ No	☐ N/A

The physicians at Boulder Valley Asthma and Allergy Clinics, PC, participate with Western States Clinical Research 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 ☐ N/A

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.

_____ _____

Signature of patient (or patient's representative) Date

_____

Printed legal name of patient (or patient's representative)

BOULDER VALLEY ASTHMA AND ALLERGY

Appointment Cancellation/No Show Policy

Boulder Valley Asthma and Allergy Clinics, PC 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.

Tardy Policy

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.

I have read the above Boulder Valley Asthma and Allergy Clinics, PC financial policy, appointment cancellation, no show and tardy policies and understand that it is my responsibility to contact the office the reschedule or cancel my appointment if necessary.

Patient/Responsible Party Signature _____ **Date** _____

DENVER ALLERGY & ASTHMA ASSOCIATES

ACCT#_____

All New Patients Need to Complete This Page

NAME: _____ **DATE:** _____

INFORMANT: ☐Patient ☐Parent ☐Other _____

REFFERING PHYSICIAN: _____

Have you or any family members been seen in our office previously? ☐Yes ☐No If yes name: _____

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

LOCAL PHARMACY: _____

MAIL ORDER PHARMACY: _____

REASON FOR APPOINTMENT:

CURRENT OR RECURRENT SYMPTOMS:

CONSTITUTIONAL ☐Fatigue ☐Fever ☐Sweats ☐Weight Gain ☐Weight Loss ☐Poor Appetite
EYES ☐Itching ☐Redness ☐Watering ☐Dryness ☐Other
EARS ☐Pain ☐Plugged ☐Itching ☐Ringing ☐Recurrent Infections ☐PE Tubes ☐Other
NOSE/SINUSES/THROAT ☐Runny Nose ☐Postnasal Discharge ☐Stuffiness ☐Sneezing ☐Nose Bleeds ☐Nasal Polyps
☐Loss of Smell/Taste ☐Snoring ☐Sinus Pressure/Headache ☐Sore Throat ☐Itchy Throat ☐Hoarseness ☐Frequent Throat Clearing
CARDIOVASCULAR ☐Chest Pain ☐Fast or Irregular Heart Rate ☐Fainting ☐Swelling of Ankles/Feet ☐Heart Murmur ☐Other
RESPIRATORY ☐Productive Cough ☐Dry Cough ☐Wheezing ☐Chest Tightness ☐Shortness of Breath ☐Coughing or Wheezing with Exercise
GASTROINTESTINAL/DIGESTIVE ☐Bloating ☐Abdominal Pain ☐Constipation ☐Diarrhea ☐Vomiting ☐Heartburn ☐Difficulty Swallowing
GENITOURINARY ☐Frequent Urinary/Bladder Infections ☐Other
For Women: ☐Currently Pregnant ☐Menopausal
For Men: ☐Prostate Problems
SKIN ☐Itching ☐Eczema ☐Hives ☐Psoriasis ☐Other Rash
NEUROLOGIC ☐Headaches ☐Seizures ☐Sleep Disturbance ☐Other
MUSCULOSKELETAL ☐Joint Swelling ☐Joint Pain ☐Muscular Pain ☐Back Pain ☐Other
ENDOCRINE ☐Cold Intolerance ☐Unusual Hair Loss ☐Excessive Thirst ☐Unexplained Weight Change ☐Other
PSYCHIATRIC ☐Depression ☐Anxiety ☐Mood Disorder ☐Other
BLOOD/LYMPH ☐Lymph Node Swelling ☐Anemia ☐Other
ALLERGY/IMMUNOLOGY ☐Allergy Swelling/Angioedema/Anaphylaxis ☐Frequent Bronchitis/Pneumonia ☐Frequent Sinusitis
ADDITIONAL NOTES/SYMPTOMS:

ENVIRONMENTAL HISTORY: (COMPLETE IF ANY RESPIRATORY OR SKIN SYMPTOMS)
Home: ☐ House ☐ Townhouse ☐ Condo ☐ Apartment ☐ Mobile Home
Years lived in Colorado: _____ ☐ Native
Years in Current Home: _____ Age of Home _____
Heating System: ☐ Forced Air ☐ Hot Water Baseboard ☐ Other
Air Conditioning: ☐ None ☐ Central ☐Window//Wall AC ☐ Evaporative Cooler
Flooring: Main Living Area ☐ Carpet ☐Wood/Tile
Bedroom ☐ Carpet ☐Wood/Tile
Basement ☐ Cement ☐ Sub floor ☐ Unfinished ☐ Carpet ☐ Wood/Tile etc. ☐ Crawl Space
Wool Carpeting/Area Rugs ☐ Yes ☐ No
Mattress: ☐ Spring ☐ Foam/Latex ☐ Air/Water Age of mattress _____
Down/Feather Bedding: ☐ None ☐ Pillows ☐ Comforter ☐ Mattress Topper
Pets: ☐ None Dogs # _____ Cats # _____ Other _____
Other Occupational or Home Exposures:

DENVER ALLERGY & ASTHMA ASSOCIATES

ACCT # _____

COMPLETE THIS PAGE ONLY IF NOT DONE ON PATIENT PORTAL

NAME: _____ **DATE:** _____

CHRONIC OR PAST MEDICAL PROBLEMS: None ☐

☐ ***Asthma***	☐ GERD	☐ Osteoporosis
☐ AIDS	☐ Glaucoma	☐ Other Autoimmune Disease
☐ ***Angioedema/Anaphylaxis***	☐ ***Hay Fever, Nasal Allergies***	☐ Other Heart Disease
☐ Barrett's Esophagitis	☐ Hepatitis (Type if known)	☐ Other Liver Disease
☐ Blood Clotting Disorder	☐ High Blood Pressure	☐ Other Lung Disease
☐ Cancer – Type:	☐ High Cholesterol and/or Triglycerides	☐ Psoriasis
☐ Cataracts	☐ ***Hives***	☐ Rheumatoid Arthritis
☐ COPD	☐ ***Immunodeficiency***	☐ Sarcoidosis
☐ Crohn's Disease	☐ Insect Sting Allergy	☐ Seizures/Epilepsy
☐ Diabetes - Type 1 Type 2	☐ 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: ☐None		

PAST SURGERIES/HOSPITALIZATIONS except for normal births: (include year) NONE ☐

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

CURRENT MEDICATIONS: (include dosage and frequency)

Prescription (include dose and frequency)	Over the Counter/Vitamins/Supplements
Drug Allergies/Adverse Reactions:	

DENVER ALLERGY & ASTHMA ASSOCIATES, P.C.

LOCAL ANESTHETIC TESTING
FLOW SHEET

Patient:_____ Acct#: _____

Date: _____ Doctor: _____ MA: _____

Anesthetic that we will be testing: _____

Histamine _____ Saline _____

Circle Interval Between Doses: 15 minutes 20 minutes 30 minutes

TIME	DILUTION	REACTION
	1:10,000	
	1:1,000	
	1:100	
	1:10	
	Full Strength ID	
	.50 cc Full Strength Sub Q	

DENVER ALLERGY & ASTHMA ASSOCIATES, P.C.

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NAME: _____ DATE: _____

FAMILY HISTORY:

	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					

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 ____
Other Tobacco	**Describe:**
Second Hand Smoke Exposure	**Frequent** □ **Occasional** □ **Rare** □
Alcohol Use	**None** □ **Former** □ **Current** □ **Average # of Drinks per day** ___ **per week** _____ **Only occasional** ___
Marijuana Use	**None** □ **Daily** □ **Occasional** □
Other Substance Use	**Describe:**

ADDITIONAL NOTES: