Southern California Allergy
phone: (818) 990-9155 fax: (818) 990-9167

PATIENT INFORMATION

Patient Name _____ DOB_____ Age _____

SSN _____ Today's Date _____

Sex _____ Single_____ Married _____

Present Address _____

City, State, Zip _____

EMAIL: _____

Occupation (if minor, guardians occupation) _____ Home phone _____

Employer Name _____ Work phone _____

Employer Address _____

City, State, Zip _____

Name of Spouse or Parent _____ Home phone _____

Address _____ Work phone _____

City, State, Zip _____

Occupation _____ Employer _____

Name of the Insured Party _____

Address _____ City, State, Zip _____

Social Security # _____ DOB _____

Home Phone _____ Work Phone _____

****How did you hear about us?** _____

FINANCIAL POLICIES

**Payment is due at the time services are rendered.
**We will see that you get the best medical care and will make every reasonable effort to aid you in obtaining the maximum benefits allowed with your insurance coverage.

ASSIGNMENT AND RELEASE

I authorize my insurance benefits to be paid to the physician. I understand that I am responsible for any deductibles, co-insurance, and non-covered services. I also authorize my physician to release any information required to process insurance claims.

Name _____ **Date** _____

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REVIEW OF SYMPTOMS

Please circle any of the following symptoms that you are currently experiencing or that you have had recently:

Constitutional: Fever, weight loss, weight gain, night sweats, severe itching, loss of appetite, fatigue, cold and/or heat intolerance

Eye, Ear, Nose or Throat: Dry eyes, itchy eyes, vision changes, cataracts, glaucoma, light avoidance, eye pain, eye discharge, itchy ears, ear infections, ringing in ears, loss of balance, loss of hearing, deviated septum, nose bleeds, post nasal drip, nasal congestion, sore throat, hoarseness, difficulty swallowing, recurrent throat infections, loss of smell and or taste, dry mouth, dental cavities

Lymph Nodes: Swelling, tenderness

Respiratory: Asthma, persistent cough, shortness of breath, chest tightness, wheezing

Heart: Chest pain, palpitations, swelling of ankles, inability to lie flat in bed

Intestinal tract: Nausea, vomiting, heartburn, indigestion, trouble swallowing liquids or fluids, abdominal pain, constipation, diarrhea, excessive gas, food intolerance, acid or sour taste in mouth, blood in stool or jaundice

Reproductive: Irregular periods, skipped periods, unusual vaginal bleeding, menopause, infertility, miscarriages, impotence, recent or current pregnancy

Urinary: Kidney stones, inability to urinate, prostate problems, kidney infections

Rheumatologic & Orthopedic: Early morning stiffness, joint swelling, joint pain, gout, low back pain, osteoporosis, fractured bones

Skin: Skin rash, hives, eczema, skin tumors or growth, excessive hair loss

Neurologic: Fainting spells, severe headaches, epilepsy (seizures), difficulty with memory, difficulty concentrating

Provide explanation on any symptoms that are particularly bothersome to you:

_____

_____

_____

Name of primary care doctor: _____

_____ _____

Patent Signature Date

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Environmental history
What type of work/ hobbies do you do?
Preschool aged children- Do they go to day care? How many days per week?
Where do you live? (country or city)
What type of heating do you have? (forced air, hot water, space heater)
Does your house have dampness, mold, or mildew problems?
Do you have an air cleaner?
Is there carpet or wood in the bedroom?
Is there carpet or wood in the main living area of the home?
Do you have dust mite covers on your mattress and pillows?
Do you have any pets? Do they come inside? (please list)
Do you smoke or do people smoke in your home?

Medical conditions					
Yes	**No**	**(check all that apply**	**Description**	**Date resolve**	**Doctor seen**
		Ear, nose, and throat issues?			
		Eye problems (glaucoma)			
		Lungs? Asthma pneumonia			
		Tuberculosis			
		Heart/ Blood pressure			
		Intestinal /stomach			
		Liver / Pancreas			
		Kidney trouble			
		Neurological (migraines)			
		Musculoskeletal disorders			
		Skin disorders			
		Diabetes			
		Cancer			
		Psychological conditions			

Hospitalizations	Cause	Date
Operations	Cause	Date

Family history	Family member and description
Allergy	
Hay fever	
Eczema	
Asthma	
Hives	
Auto immune diseases	

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Acknowledgment and Consent

____ (initial) **Consent to Treatment**
I consent to the performance of allergy services/testing by my medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I understand that by signing this consent I am agreeing to allergy testing and treatment by Southern California Allergy.

_____ (Initial) **Appointments**
I have been instructed that I must bring my epipen to every visit where I receive an allergy injection and that my appointment may be rescheduled if I do not do so. I understand that should I miss or reschedule an allergy injection appointment that the physician may decide to repeat a dose or go back in my schedule for safety reasons and this could potentially change my immunotherapy schedule. I have been requested to take an antihistamine 1 hour before allergy injections. **I understand that cancelling an appointment without 24 hour notice or not showing up for an appointment could result in a charge of $35 by Southern California Allergy.**

____ (Initial) **Insurance Contract**
I understand that SCA has a contract with the insurance carrier which requires them to bill all applicable copayments, co-insurances, and deductibles to the patient/insured as directed by the carrier. Requests for adjustment of these obligations is in direct violation of these insurance contracts and could jeopardize the physician and practices participating provider status. Therefore these requests cannot be accepted. Please make sure you understand your financial obligation and insurance coverage before beginning any treatment.

____ (initial) **Financial Policy**
I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Southern California Allergy for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. I also understand that I am encouraged to check my benefits prior to my appointment and that although I may receive an explanation of benefits, that this is **not** a guarantee of coverage or benefits.

1. **There is a $25.00 fee for returned checks.**

____ (initial) **Release of Medical Information**
I, (print patient name) _____, have read a copy of *Southern California Allergy's Notice of Privacy Practices.* (This document is available at our front desk or at www.Encinoallergy.com)
I authorize information to be released to the following individuals:
Name:_____ check one: [◊ Medical] [◊ Financial]
Name:_____ check one: [◊ Medical] [◊ Financial]
Name:_____ check one: [◊ Medical] [◊ Financial]

I, _____, have read and understand the above and agree to the terms stated above.

_____ _____
Responsible Party Signature **Date**