NEW PATIENT INFORMATION RECORD

(PLEASE PRINT)

PATIENT INFORMATION (*Required fields)

PATIENT'S NAME*	SEX AGE	DATE OF BIRTH*	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER
MAILING ADDRESS*	CITY AND STATE		ZIP CODE*	HOME PHONE NUMBER*
EMAIL ADDRESS				CELL PHONE NUMBER
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE NUMBER	
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
SPOUSE'S NAME			SOCIAL SECURITY NUMBER	
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE NUMBER	
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
REFERRING PHYSICIAN OR PRIMARY CARE PHYSICIAN**			PHONE NUMBER	
PHARMACY NAME**			PHONE NUMBER	

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	DATE OF BIRTH	MAILING ADDRESS, CITY, STATE, ZIP		HOME PHONE NUMBER
MOTHER'S EMPLOYER	OCCUPATION		SOCIAL SECURITY NUMBER	BUSINESS PHONE NUMBER
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
FATHER'S NAME	DATE OF BIRTH	MAILING ADDRESS, CITY, STATE, ZIP		HOME PHONE NUMBER
FATHER'S EMPLOYER	OCCUPATION		SOCIAL SECURITY NUMBER	BUSINESS PHONE NUMBER
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE

EMERGENCY CONTACT*

NAME	PHONE NUMBER	RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE*	EFFECTIVE DATE*	I.D. #	GROUP #
NAME AND ADDRESS			
POLICY HOLDER"S NAME*	DATE OF BIRTH**	SEX	GROUP #
SECONDARY INSURANCE*	EFFECTIVE DATE*	I.D. #	GROUP #
NAME AND ADDRESS			
POLICY HOLDER"S NAME*	DATE OF BIRTH**	SEX	GROUP #

It is the responsibility of the patient to understand the policies and benefits of their insurance. This includes (1) required referrals obtained and presented prior to services rendered; (2) co-payments/co-insurance (3) covered benefits; (4) prior authorization procedures. We require co-payment/co-insurnace to be paid on the date of service rendered. ASSIGNMENT OF BENEFITS: I hereby authorize the undersigned physician to furnish information to insurance carriers concerning this illness/accident. And I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original. I authorize the physicians and extenders of Capital Allergy and Respiratory Disease Center to perform such diagnostic procedures and/or treatment, as they deem necessary.

PATIENT/INSURED SIGNATURE _____ **DATE** _____

Capital Allergy and Respiratory Disease Center
Patient Medical History Form

Patient Name: _____ Date: _____
Date of Birth: _____ Occupation: _____

Past Medical History: Do you have or have you had any of the following: (please circle answers)

Diabetes	Yes	No	High or Low Blood Pressure	Yes	No
Cancer	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Arthritis/Gout/Rheumatism	Yes	No
Convulsions	Yes	No	Blood Disease	Yes	No
Hay Fever or Asthma	Yes	No	Venereal Disease	Yes	No
Lung Disease	Yes	No			
Have you ever had a blood transfusion?	Yes	No			
Are you taking or have you ever taken steroids for any reason?	Yes	No			

Current Medications:

	Name	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			

Drug Allergies (please list) _____

Past Surgeries and Dates, if known:

1. _____ Year: _____ 4. _____ Year: _____

2. _____ Year: _____ 5. _____ Year: _____

3. _____ Year: _____ 6. _____ Year: _____

Have you ever been advised to have a surgical procedure that which has never been done? Yes No
If so, please state the procedure and when it was recommended? _____

Social History: (please circle the answers that are applicable)

1. Do you smoke? Yes No
If yes, how many years? _____ Number of packs per day _____
If you quit, when did you quit? _____ How many packs a day did you smoke? _____
2. Do you use recreational drugs? Yes No
3. Do you drink alcohol? Yes No
How many drinks per week? _____
4. Do you work in a noisy environment? Yes No
5. Are you frequently exposed to loud noises? Yes No
6. Have you ever been in the military? Yes No

Reason for seeing the Doctor today:

_____
_____
_____

Family Medical History:

	Diseases Known	If deceased, cause of death
Father	_____	_____
Mother	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Grandparents		
	_____	_____
	_____	_____

Review of Systems: Please indicate if you are now experiencing any of the following. (please circle)

Recent weight change	Yes	No	Joint pain	Yes	No
Fever	Yes	No	Joint stiffness or swelling	Yes	No
Fatigue	Yes	No	Muscle pains or cramps	Yes	No
Headaches	Yes	No	Dizziness	Yes	No
Chest Pain/Angina Pectoris	Yes	No	Convulsions or Seizures	Yes	No
Heart trouble	Yes	No	Chronic or frequent coughs	Yes	No
Palpitation	Yes	No	Spitting up blood	Yes	No
Swelling of feet, ankles, hands	Yes	No	Shortness of breath	Yes	No
Slow to heal after cuts	Yes	No	Burning or painful urination	Yes	No
Bleeding or bruising tendency	Yes	No	Kidney stones	Yes	No
Anemia	Yes	No	Blood in urine	Yes	No
Diabetes	Yes	No	Incontinence	Yes	No
Excessive thirst or urination	Yes	No	Moles that are irritated or bleeding	Yes	No
Very dry, flaky skin	Yes	No	Sores that have not healed	Yes	No
Eye disease or injury	Yes	No	Rash or itching	Yes	No
Blurred or double vision	Yes	No	Change in skin color	Yes	No
Glaucoma	Yes	No	Varicose veins	Yes	No
Loss of appetite	Yes	No	Change in hair or nails	Yes	No
Frequent diarrhea, nausea or vomiting	Yes	No	Snoring	Yes	No
Abdominal pain or heartburn	Yes	No	Sleep apnea	Yes	No
Peptic Ulcer (duodenal or stomach)	Yes	No	Sinus problems	Yes	No
Memory Loss or confusion	Yes	No	Nasal Blockage	Yes	No
Nervousness	Yes	No	Hoarseness	Yes	No
Depression	Yes	No	Difficulty swallowing	Yes	No
Insomnia	Yes	No	Hearing loss or ringing in the ears	Yes	No
Thyroid Problems	Yes	No	Nose bleeds	Yes	No
			Bleeding gums or mouth sores	Yes	No

If the answer to any of these is yes, please explain:

_____
_____
_____
_____

Patient Signature: _____

Reviewed by Doctor: _____ Date: _____

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

BRADLEY E. CHIPPS, M.D.
Pulmonary & Allergic Diseases
Board Certification:
Pediatrics
Pediatric Pulmonology
Allergy and Clinical Immunology

Medical Director, Cystic Fibrosis Center
Assoc. Medical Director Sleep Laboratory
Medical Director of Respiratory Therapy
Sutter Community Hospitals

TRAVIS A. MILLER, M.D.
Allergic and Immunologic Diseases
Board Certification:
Internal Medicine
Pediatrics
Allergy and Clinical Immunology

Evelyn Keaton, A.C.N.P-BC
Acute Care Nurse Practitioner

Hannah Choi, C.P.N.P.
Pediatric Nurse Practitioner

Patient Responsibilities

As you may be aware, current healthcare has entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on ***you*****.** This includes knowing which facilities can be used for radiology, laboratory, hospitalization or surgery. We request that you become familiar with your insurance coverage booklet prior to your first appointment, as benefits and prescription coverage can fluctuate greatly from plan to plan, and year to year.

The patient is responsible for co-payments/co-insurance, deductibles, non-covered services and/or amounts that insurance denies. Regardless of the type of coverage you have, we will ask you to provide your insurance card at each visit. We may also request identification. You will be held financially responsible if your coverage is not in effect at the time of your visit; payment is due when services are rendered unless previous arrangements have been made. We strongly advise that you fully understand your coverage regarding antigen and allergy shots before you sign (on a different form) to accept financial responsibility for these services. If you do not pay your co-pay/co-insurance when you come in for an allergy shot, it will not be given. If you do not have your co-pay/co-insurance at the time of your office visit appointment, you will be billed for the co-pay, plus a $10.00 service charge. If the patient is a minor, whichever parent signs for financial responsibility will be billed, no exceptions.

Our office is happy to provide your medical records to other doctors and in instances of court hearings, such as custody or divorce proceedings. However, the patient or guardian may be responsible for a fee. Our office will not provide any further documentation or letters in cases of custody and divorce proceedings.

Unless otherwise instructed, our office may call the phone number(s) listed on the patient's account and may leave information such as our practice name, the patient's name and nature of the call. If you prefer we not leave detailed voicemails on the listed phone number(s), please notify the receptionists.

I indicate by signing below, that I have received this notice, and am aware of financial responsibility for my account.

_____ _____

Signature of Patient/Parent Date

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness ……..……..

Printed Name of Individual or Legal Representative ……...

Witness……

Date: ……

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Others (please specify)

_____
_____
_____

_____ _____
HIPAA Officer Date

MAIN OFFICE: 5609 J STREET, SUITE C • SACRAMENTO, CA 95819 • (916) 453-8696 • FAX (916) 453-8715
FOLSOM OFFICE: 1561 CREEKSIDE DRIVE, SUITE 130 • FOLSOM, CA 95630
ROSEVILLE OFFICE: 1451 SECRET RAVINE PARKWAY, SUITE 150 • ROSEVILLE, CA 95661

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness ……..

X Printed Name of Patient or Legal Representative Witness ……

Date: ……..

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Instruction for Patients Prior to Allergy Skin Testing

Allergy Skin testing provides a fast, safe and reliable means for identifying allergic sensitivities to inhalant allergens (e.g., pollens, molds, dust mites and animal dander) and is also used sometimes to diagnose allergic sensitivities to insect stings, antibiotics and foods. The information obtained from allergy testing provides guidance for avoidance of allergens; the most important and first step in the treatment of any allergic disorder. Test results may also be used to formulate allergy shot extracts. In order to make your allergy testing appointment as productive as possible, we ask that you review the following instructions prior to your appointment:

1. Please allow a total of 2-3 hours for complete allergy testing. Although the testing itself may be completed in one hour or less, additional time may be needed to discuss results, allergy avoidance measures and treatment options.
2. Wear a shirt or blouse, which can be removed easily. If prick tests are negative, your doctor may request intradermal in the arm for further evaluation.
3. The medications listed below will interfere with allergy skin testing and should be discontinued for the time specified. If you have a medical condition or severe allergic symptoms, which might worsen without medications, please consult us prior to stopping these medications. If you have forgotten to stop these medications by the specified time, please consult one of our nurses to determine whether or not you need to reschedule your allergy testing appointment. All other medications, which are not listed below, will not interfere with skin testing and should be continued as prescribed.

Antihistamines / Decongestants
(DO NOT TAKE 5-7 DAYS PRIOR TO A TEST VISIT)

Alavert
Astelin Nasal Spray
Astepro Nasal Spray
Atarax
Azelastine (Astelin)
Benadryl
Bromphenerimine
Cetirizine (Zyrtec and Zyrtec D)
Chlortrimeton
Cimetidine
Clarinex
Claritin (Loratadine)
Diphenhydramine
Doxepin
Fexofenadine (Allegra/ Allegra D)
Hydroxyzine
LevoCetirizine (Xyzal)
Pataday
Patanase
Ryna 12
Tagamet
Xyzal
OTC Cough/Cold/Allergy Meds

DO NOT STOP YOUR ASTHMA OR OTHER RESPIRATORY MEDICATIONS UNLESS INSTRUCED BY YOUR PRIMARY DOCTOR OR OUR MEDICAL STAFF

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