ALLERGY & ASTHMA CENTER OF WESTERN COLORADO, P.C.
1120 Wellington Ave., Grand Junction, CO 81501
Telephone: (970) 241-0170 OR 1-800-247-2360 FAX (970) 241-2035
www.allergywesterncolorado.com

PATIENT REGISTRATION

Please complete this ENTIRE form BEFORE coming for your initial appointment. Bring this form with you to your initial appointment. Please be prompt for all appointments. See our patient information brochure for our office policies, billing, insurance procedures, and important appointment information. This is also available online under "New Patient Info" tab.
Antihistamines interfere with allergy skin testing. See patient information brochure for medications to avoid before your appointment. Your initial appointment may last 1-3 hours if skin testing is indicated.

Patient's Name _____ M / F Birthdate _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Phone: Home _____ Work _____ Cell _____

Email _____ **Communication via email requires a signature on the attached Patient email consent form*

Patient's Primary Physician _____ City _____ State _____

Referred By (Self, Physician, Other) _____

Person responsible for payment of medical bills _____ Birthdate _____

Relationship to patient _____ Soc. Sec. # _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Position Held _____ Phone _____

Name of spouse or 2nd parent _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Employer _____ Position Held _____ Phone _____

Nearest responsible relative other than parent or spouse _____ Phone _____

Address _____ City _____ State _____ Zip _____

Have you or any of your immediate family members been seen here as a patient? Yes ___ No ___ If yes, please list name and relationship to patient _____ Year Seen _____

Name of insurance company _____ Secondary insurance _____

Subscriber number _____ Subscriber number _____

Group number _____ Group number _____

Policy holder name _____ Policy holder name _____

Authorization: I hereby authorize physicians of Allergy and Asthma Center to furnish information to my insurance carrier(s). I understand that I am responsible for any amount of charges not covered by my insurance or all charges if I do not have any insurance. In the event that it becomes necessary to employ an attorney or collection agency to enforce collection of such account, I agree to pay all costs incurred as well as reasonable attorney's or collection fees. I authorize my insurance company to pay medical benefits to physicians of Allergy and Asthma Center for services described on my insurance form.

Signature: _____ Date: _____
Circle one: Patient Parent Legal Guardian

I authorize Allergy and Asthma Center to release and / or discuss my health and / or billing information with:
_____ Relationship: (circle one) spouse, parent, child, other _____

Patient's signature (parent if patient is a minor) _____ Soc. Sec. # _____

ALLERGY & ASTHMA CENTER OF WESTERN COLORADO, P.C.

Patient Name:_____ DOB:_____ Date of Visit:_____

Please complete the following **MEDICAL HISTORY FORM** *and bring completed form to your first appointment*

Medical History

1. What are the problems you would like evaluated? Please state your primary concern first. How long have you had each of these problems?

2. What do you think makes your problems worse?

3. Please list the name, dose, and how often you take medications for your allergies, asthma or hives. (Bring all your medication bottles with you to your first appointment.) (For other medications see number 4 below)

4. Please list any other medications you take for other medical problems either by prescription or over the counter.

5. List any other medical problems you have:

6. Check previous surgeries: Tonsils removed_____, Adenoids removed_____, Sinus surgery_____, Nasal polyps removed_____, Ventilation tubes placed in ear(s)_____, Other surgeries_____

7. Is there a family history of allergy / asthma / eczema / food allergy? If so, who?

   List family history of other medical problems

8. Do you live in a house, apartment, townhouse or trailer? How long have you lived there?

9. Do you live in a rural area? Yes_____No_____ Crops grown on your land? Yes_____No_____

10. Please list any animals inside your home: In your bedroom? Yes_____No_____Occasionally_____
List animals outside your home:

11. Do you sleep near a feather pillow or down comforter? Yes_____No_____

12. How is your home heated? Baseboard Forced Air Wood Stove Pellet Stove In Floor Heat

13. How is your home cooled? Swamp Cooler (evaporative) Air Conditioning Open Windows

14. How long have you lived in the Colorado / Utah area? Where did you live before?

15. Do you currently smoke? Yes_____No_____ How many years? _____ How many packs per day? _____
Did you ever smoke? Yes_____No_____ How many years? _____ How many packs per day? _____ Year you stopped _____
Do you now live with a smoker? Yes_____No_____ Do they smoke in your home or car? Yes_____No_____Occasionally____
Do you currently or have you in the past chewed tobacco? Yes_____No_____

16. What is your occupation?
Are your symptoms worse or better at work, home, out of town, or no difference?

17. Do you have any unusual exposure with your occupation or other activities that could affect your allergic problems?

18. Do you have any food allergies? Yes_____No_____ To what? What happens when you eat this?

19. Are you aware of any medication allergies? Yes_____No_____ If so, list them. What type of reaction and when did you have this happen?

20. Who else lives in your house? Spouse_____ Children_____ Siblings_____ Roommate_____ Live alone_____

21. Do you receive help from your insurance for medication costs? Yes_____No_____Not much_____
Is medication cost a major problem for you? Yes_____No_____

22. Any psychological, social or financial problems which affect your health? Yes_____No_____

23. Do you have a problem with excessive alcohol use or illegal drug use? Yes_____No_____

24. Have you had any lab work or x-ray's for your allergy / asthma / skin problems? Yes_____No_____

25. Have you ever had allergy skin testing? Yes_____No_____ Did you require allergy shots? Yes_____No_____Dates_____

26. Anything else you think we may need to know about your health?

27. Current review of symptoms: (Check if this is a problem of yours)

_____ Unusual weight gain / loss
_____ Unusual fatigue
_____ Sleep problems
_____ Sleep apnea
_____ Loud snoring
_____ Visual problems
_____ Hearing difficulty
_____ Swallowing difficulty
_____ Heartburn occurring several times a week or more
_____ Regurgitation (acid reflux)
_____ Shortness of breath
_____ Coughing
_____ Chest pain or pressure
_____ Chest or neck tightness
_____ Abdominal pain
_____ Vomiting, nausea
_____ Diarrhea
_____ Blood in stool or black stool
_____ Urination difficulty
_____ Female menstrual problems
_____ Headache or sinus pressure
_____ Weakness
_____ Balance problems, vertigo or dizziness
_____ Blocked or plugged ears
_____ Postnasal drip, throat clearing
_____ Recurrent hoarseness

Allergy & Asthma Center of Western Colorado, P.C.

William A. Scott M.D. / David R. Scott, M.D. / Cathryn E. Schnell, P.A.-C

Health Summary

Name_____ Date_____

Present Health Conditions

Disease	Yes	No		Disease	Yes	No
Asthma				Gallstones		
Emphysema/Chronic Bronchitis				Kidney Disease, Type		
COPD				Kidney Stones		
Acid Reflux (GERD)				Prostate Problems		
Sinus Infection (Chronic)				Gout		
Ear Infections (Chronic)				Arthritis		
Skin Allergy				Stroke		
Eye Allergy				Epilepsy/Seizures		
Skin Disease				Diabetes/High Blood Sugar		
Heart Attack				Thyroid Problems, High or Low		
Irregular Heart Beat				Cancer, Type		
Congestive Heart Failure				Anxiety/ Depression		
Heart Murmur				Glaucoma		
Rheumatic Fever				Ulcers/Stomach		
High Cholesterol				Liver Disease, Type		
High Blood Pressure				Anemia/ Low Blood		
Blood Clot in Lung				Bleeding Problems, Type		
Blood Clot in Leg				Blood Transfusion		
Tuberculosis				Other:		

Surgeries

Surgery Type	Yes/Date	No		Surgery Type	Yes/Date	No
Tonsils				Abdominal Surgery		
Adenoids				Joint Scope Surgery		
Ear Tubes				Joint Replacement		
Sinus Surgery				Back Disc Surgery		
Nasal Polyp Surgery				Prostate Surgery		
Reflux Surgery/Nissan				Hernia Surgery		
Neck Artery Surgery				Cataract Surgery R or L		
Open Heart/Catheterization				Other Surgeries:		
Appendectomy						
Gallbladder Removal						

Date Reviewed/Initial				

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information.

I hereby consent to Allergy & Asthma Center of Western Colorado, P.C. (Allergy Center) using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out Allergy Center's health care operations. I also consent to Allergy Center using or disclosing my protected health information for treatment purposes to another health care provider or entity involved directly or indirectly in my treatment. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competency of health care professionals.

I further acknowledge Allergy Center has provided me a copy of it's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Effective April 14, 2003, due to federal regulations HIPAA, we are required to have a release form signed by the patient before we can give out any medical information to any person other than the patient.

Please list below the names and relationships of any authorized individuals with whom we may discuss your medical information.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____

If we cannot reach you, may we leave medical information on:

Home answering machine	YES	NO
Cell Phone	YES	NO

_____ _____
Name of Patient (please print) Date of Birth

_____ _____
Signature of Patient or Parent or Legal Guardian Date

_____
Print name of Parent or Legal Guardian

PLEASE STOP ANTIHISTAMINES 5 DAYS PRIOR TO NEW PATIENT APPOINTMENTS OR ALLERGY SKIN TESTING

***Do not stop asthma medications or any other medications that do not contain antihistamine!**
****If you have major hives or swelling, do not stop your antihistamines.**
*****Please call us if you have questions about any of your medications interfering with skin testing.**
******Do not use oil, cream or lotion on the back or arms for 24 hours prior to skin testing.**

COMMON MEDICATIONS CONTAINING ANTIHISTAMINES

- Actifed (chlorpheniramine)
- Advil PM, Advil Allergy
- Alavert/Claritin (loratadine)
- Allegra (fexofenadine)
- Alka Seltzer P.M.
- Amitriptyline (Elavil)
- Antivert (Meclizine)
- Astelin Nasal Spray (azelastine)
- Astepro Nasal Spray (azelastine)
- Atarax (hydroxyzine)
- Azelastine nose spray (Astepro, Astelin)
- Benadryl (diphenhydramine)
- Bonine (meclizine)
- Cetirizine (Zyrtec)
- Chlorpheniramine (Chlor-Trimeton, Actifed, Tussionex)
- Chlor-Trimeton (chlorpheniramine)
- Clarinex (desloratadine)
- Claritin (loratadine)
- Clemastine (Tavist)
- Cogentin (for Parkinson's disease)
- Comtrex
- Contac
- Coricidin
- Cyproheptadine (Periactin)
- Dallergy
- Desipramine (Norpramine
- Desloratadine (Clarinex)
- Diclesis
- Dimenhydrinate (Dramamine)
- Diphenhydramine (Benadryl)
- Dimetane
- Dimetapp (brompheniramine)
- Doxepin (Sinequan, Adapin)
- Doxylamine
- Dramamine (dimenhydrinate)
- Drixoral
- Duravent LA
- Dymista
- Elavil (amitriptyline)
- Excedrin PM
- Fexofenadine (Allegra)
- Hydroxyzine (Atarax, Vistaril)
- Imipramine (Tofranil)
- Levocetirizine (Xyzal)
- Loratadine (Claritin)
- Meclizine (Antivert, Bonine)
- Norpramine (desipramine)
- Nortriptyline (Pamelor)
- Nyquil
- Nytol
- Olopatadine (Patanase nasal spray)
- Pamelor (nortriptyline)
- Patanase Nasal Spray (olopatadine)
- PBZ (pyribenzamine)
- Pediacare
- Periactin (Cyproheptadine)
- Phenergan (promethazine)
- Promethazine (Phenergan)
- Protriptyline (Vivactil)
- Pyribenzamine (PBZ)
- Robitussin Allergy
- Rondec
- Rynatan
- Sinequan (doxepin)
- Sominex
- Sudafed Cold/Plus (Plain Sudafed is okay)
- Surmontil (trimipramine)
- Tavist (clemastine)
- Theraflu
- Tofranil (imipramine)
- Tylenol PM & similar over the counter sleep aids
- Tussionex (chlorpheniramine)
- Unisom (doxylamine)
- Vistaril (hydroxyzine)
- Vivactil (protriptyline)
- Zyrtec (cetirizine)
- Xyzal (levocetirizine)

*** Cough/Cold/Allergy or Sinus medications bought over the counter may have antihistamine in them.**

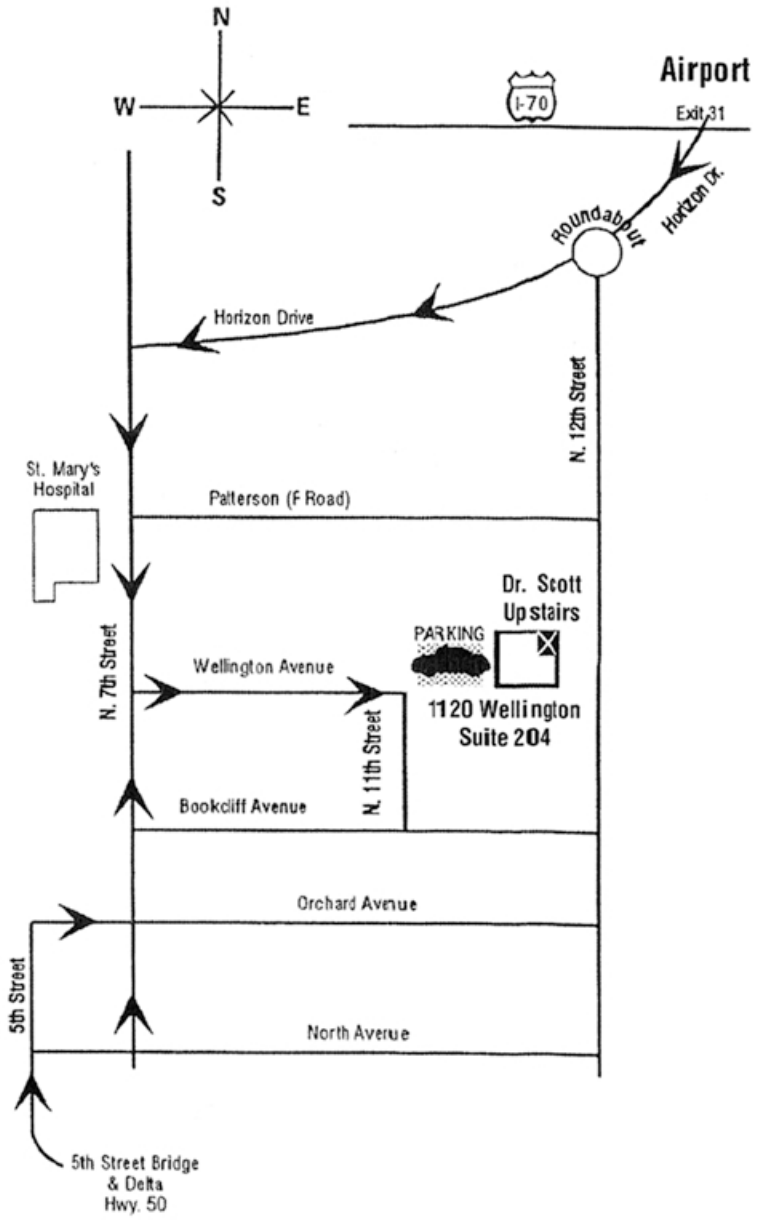
*** Sleeping aids over the counter often contain antihistamines and should be stopped. Prescription medications for sleep that do not contain antihistamines may be continued. Exceptions are amitriptyline (Elavil), doxepin, desipramine and imipramine, which are also prescribed for pain or depression, and contain antihistamines and should be stopped 5 days prior to your first appointment or allergy testing.**

*** Antihistamine allergy eye drops (Patanol, Pataday, olopatadine, Elestat, Optivar, Bepreve, Lastacaft) and other over the counter allergy eye drops such as Zaditor, ketotifen, Naphcon-A, Opcon-A, Visine AC and all generic allergy eye drops should be stopped 5 days prior to your first appointment or allergy skin testing.**

*** Plain Sudafed (pseudoephedrine) and phenylephrine are only decongestants and when not added in with an antihistamine are okay and do not need to be stopped. Afrin (oxymetazoline) and NeoSynephrine (phenylephrine), decongestant nose sprays, are also okay. All steroid nose sprays are okay.**

Allergy and Asthma Center
of Western Colorado

1120 Wellington Avenue, Suite 204 970.241.0170



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Email: scottmd@allergywest.org

P A T I E N T E - M A I L C O N S E N T F O R M

Patient name: _____

DOB:_____

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from the Dr. Scotts, Cathryn Schnell and the Practice are not encrypted, so E-mails may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail senders can easily misaddress an E-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
Practice server could go down and E-mail would not be received until the server is back on-line.
i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **E-mail is not appropriate for urgent or emergency situations. Practice and Physician cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.**
b) **If the patient's E-mail requires or invites a response from Practice or Physician, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.**
c) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
d) **All E-mail will usually be printed and filed in the patient's medical record.**
e) Office staff may receive and read your messages.
f) Practice will not forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use E-mail for

communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.

h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by E-mail with Practice.

3. INSTRUCTIONS

To communicate by E-mail, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Practice of changes in his/her E-mail address.
e) Acknowledge any E-mail received from the Practice and/or Physician.
f) Take precautions to preserve the confidentiality of E-mail.
g) Protect his/her password or other means of access to E-mail.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **Allergy and Asthma Center of Western Colorado** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature_____ Witness signature _____

Date_____ Date _____