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

PATIENT REGISTRATION

To help us better address your concerns, please complete this ENTIRE form BEFORE coming to your initial appointment. We ask that you bring the completed form with you and arrive prior to your scheduled appointment time. Please see our patient information brochure for our office policies, billing, insurance procedures and important appointment information. This information is also available online under "New Patients" tab.

****Note- Anti-histamines and some additional medications will interfere with allergy skin testing. Please refer to the patient information brochure or our website for a list of medications to avoid before your appointment. Your initial appointment may last between 1-3 hours if skin testing is indicated.**

PATIENT'S NAME _____ M / F BIRTHDATE _____
First Middle Last

ADDRESS _____ CITY _____ STATE_____ ZIP _____

SOCIAL SECURITY # _____ PHONE HOME _____ WORK _____ CELL _____

EMAIL: _____ Note- Email address is used for patient portal access (https://8837.portal.athenahealth.com)

PATIENT'S PRIMARY CARE PHYSICIAN _____ CITY _____ STATE _____

REFERRED BY (SELF, PHYSICIAN, OTHER) : _____

PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL BILLS: _____ BIRTHDATE _____

RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY # _____ 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/ 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 THE 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 the Allergy & 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 insurance. In the event that it becomes necessary to employ an attorney or collection agency to enforce collection of such amount, 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 the Allergy & Asthma Center for services described on my insurance form.

SIGNATURE: _____ DATE _____
Circle One: Patient Parent Legal Guardian

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & 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 carrying 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 are 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 with a copy of it's Notices of Privacy Practices, which provides a detailed description of 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 a voicemail? YES NO

Note- All electronic communication with the Allergy Center is requested to be conducted through our patient portal in order to remain HIPAA compliant.

_____ _____

Name of patient (please print) Date of birth

_____ _____

Signature of Patient or Parent/ Legal Guardian Date

_____

Signature of Parent/ Legal Guardian

Allergy & Asthma Center of Western Colorado Patient Questionnaire

Thank you for answering the following questions so we may better assist you

Patient Name: _____Date of Birth:_____ Date of Visit: _____

What is the reason for your visit and duration of problem?

Have you had previous imaging/ labs/ testing related to your visit today? Yes No **If yes, please explain**

_____

Do you have breathing concern? YES NO (If no, may skip)

How long have you had this issue? _____

Circle any respiratory diagnoses you have: Asthma COPD Reactive airway Disease (RAD) Bronchitis

Symptoms: Cough Wheeze Shortness of breath Chest tightness Difficulty exercising Waking up at night

What triggers your breathing symptoms? Illness Pollen Animals Exercise Cold / Heat Changes in weather
Tobacco smoke Wildfire smoke Poor air quality Scents/odors (perfumes)
Taking aspirin or ibuprofen Reflux/ heartburn

Have you had and ER / Urgent Care in the past year because of breathing issues? Yes No **If yes, when**_____

Have you been admitted to the hospital for breathing issues? Yes No **If yes, when**_____

Have you ever required steroids (oral or injection) to control your breathing issues? Yes No

Have you ever used an albuterol/ quick acting rescue inhaler? Yes No **If yes, how often do you use it?** _____

If using albuterol, how many times per week have you used that recent? _____

Have you ever used a steroid daily maintenance/ controller inhaler? Yes No **If yes, which one(s)?** _____

If coughing:

Cough seems to come from: Deep in the chest Throat clearing/drainage

Is your cough: Dry Productive for clear mucus Productive for colored mucus:_____ (color)

Cough is worse: When lying down After eating With exertion With cold air Other: _____

Do you have nasal, sinus or eye allergy concerns? YES NO (If no, may skip)

How long have you had allergy symptoms? _____ **How long have you lived in area?** _____

Circle all allergy symptoms you have:

Nasal symptoms: Congestion Runny nose Sneezing Itching Post-nasal drip Decrease/ Loss of sense of smell

Eye symptoms: itching Watery Swelling Redness Pain Blurred vision

Other: Sinus pressure Headache Sinus infections – If yes, how many per year? _____

What seasons do you have allergy symptoms: Year-round Spring Summer Fall Winter

What triggers your allergy symptoms? Pollen Cat Dog Other Animals: _____

Changes in weather Strong scents/odors/perfumes Exercise Cold air Tobacco smoke Eating Uncertain

What medications have you tried/ do you take and are they helpful?

_____

_____

Have you previously had allergy testing? Yes No **If yes, when/ where?** _____

Have you previously been on allergy immunotherapy? Yes No **If yes, when/how long**? _____

Medication Allergies YES NO (If no, may skip) Yes No (If no, may skip)

Please list concerning medication(s) and the reaction it caused:

_____

_____

Did you need to take any medications or seek medical attention? Yes No. If yes, please explain_____

Do you have food allergy concerns? YES NO (If no, may skip)

Please list concerning food(s) and the reaction it caused:

_____

_____

_____

Did you need to take any medications or seek medical attention? Yes No. If yes, please explain_____

Do you still eat this food? _____

Do you have insect allergy concerns? YES NO (If no, may skip)

Please list concerning insect(s) and the reaction it caused:

_____

_____

Did you need to take any medications and/or seek medical attention? Yes No **If yes, please explain**_____

Do you have an epinephrine injection device? Yes No. **If yes, have you ever needed to use it?** _____

Do you have problems with skin rashes? YES NO (If no, may skip)

How long have you had the rash?_____ **Is it chronic or does it come and go?** _____

What part(s) of your body does it affect?_____

Does anything seem to trigger it/ make it worse? _____

What have you tried to make it better? _____

Any previous evaluation for the rash? _____

Do you have other allergy related concerns? If yes, please explain.

_____

_____

Living Environment:

How long have you lived in Colorado/Utah area? _____ **Where did you live before?** _____

Do you live in a: house apartment townhouse/duplex trailer other: _____ **How long?** _____

Rural area? Yes No **Crops on land?** Yes No

Heating: Baseboard Forced Air Wood / Pellet Stove In Floor Heat

Cooling: Swamp/Evaporative Cooler Central Air Conditioning Open Windows

Type of Flooring in main house: _____ **Bedroom:** _____

Type and number of pets inside: ___ Dog(s) ____ Cat(s) Other:_____ **Allowed in bedroom?** Yes No

Type and number of pets outside: ___ Dog(s) ____ Cat(s) ____ Horse(s) Other:_____

Who else lives with you (patient)?_____

Patient Name: _____Date of Birth:_____ Date of Visit: _____

Social History:

Are you currently working? Yes No **If yes, what is your job/occupation?** _____

Are your symptoms better / worse at work? **Out of town?** **No difference**

Any exposures at work /hobbies or other activities that could affect your breathing/allergy concerns? Yes No

If yes, please explain_____

Are you a current smoker? Yes No **Are you a former smoker?** Yes No **If yes, when did you quit?** _____

If yes, how many years? _____ **How many packs per day?** _____

Please circle products used: Cigarettes Cigars Marijuana Vape/ E-cigarettes Chewing tobacco

Do you currently live with smoker? Yes No **Do they smoke in home?** Yes No **Car?** Yes No

History of excessive alcohol use? Yes No

History of Illegal drug use? Yes No

Any Psychological, social or financial problems which affect your health? Yes No **If yes, please explain:** _____

Past Medical History (please circle):

Acid Reflux/ Heartburn	High Blood Pressure	Diabetes
Sleep Apnea	High Cholesterol	Arthritis
Thyroid -High/ Low	Heart Disease: _____	Cancer- Type:_____
Depression/ Anxiety	Blood Clot - Leg/ Lung	Glaucoma

Other(s): _____

_____

Please list all CURRENT medications to include over the counter medications & supplements to include dose/ frequency?

Do you receive an annual influenza vaccine? Yes No. **If yes, when was your last one?** _____

Have you been vaccinated for COVID-19? Yes No **If yes, which one/ number doses?** _____

Have you received a pneumonia vaccine? Yes No **If yes, when & which one?** _____

Previous Surgical History (please circle and note date(s) and additional details if relevant):

Tonsils/Adenoids

Ear Tubes

Sinus Surgery

Nasal Polyp Surgery

Open Heart Surgery/ Catheterization

Joint Surgery

Other: _____

Family History (Please check if family history of following and list which relatives- parents, siblings, children, grandparents, aunts, uncles)

_____ **Asthma** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

_____ **Hay fever/ Environmental Allergies** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

_____ **Eczema** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

_____ **Food Allergy** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

_____ **Hives / Swelling** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

_____ **Auto-Immune Disease** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

_____ **Recurrent Infections (Pneumonia/ Sinus etc)** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

_____ **Cystic Fibrosis** (Please circle: Mom Dad Sister Brother Son Daughter Other: _____)

Other:

Review of Symptoms: (Please check if is a CURRENT problems in past several weeks)

_____ Unusual Weight Gain/ Loss

_____ Unusual Fatigue

_____ Sleep Problems

_____ Snoring

_____ Visual problems

_____ Hearing difficulty

_____ Swallowing difficulty

_____ Heartburn/ Acid Reflux

_____ Shortness of breath

_____ Coughing

_____ Chest pain or pressure

_____ Chest tightness

_____ Fevers / Chills / Night sweats

_____ Skin rashes

_____ Abdominal pain

_____ Vomiting/ nausea

_____ Diarrhea

_____ Blood in stool/ black stool

_____ Urinary difficulty

_____ Headache/ sinus pressure

_____ Balance problems/ vertigo/ dizziness

_____ Blocked or plugged ears

_____ Post nasal drainage / throat clearing

_____ Recurrent hoarseness

_____ Joint pain/ swelling/ redness

Thank you.