Allergy & Asthma Center
of Southern Oregon, PC

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Phone (541) 858-1003 Fax (541) 857-4499

Patient Information

Patient Name: _____ _____ _____ **DOB:** _____ **Age:** _____ **M / F / Other**
First M Last

Mailing Address: _____
Street City State Zip Code

Primary Phone: _____ ❑Home ❑Cell **Secondary Phone:** _____ ❑Home ❑Cell **Email:** _____

Okay to Contact via ❑ Text ❑ Email for: ❑Appointments ❑Medications ❑Medical Records ❑Other _____

By Indicating that you would like to receive emails you are giving consent to send Personal Health Information (PHI) via Email and understand the risk of unencrypted email

Emergency Contact: _____ **Relation:** _____ **Emergency Phone:** _____ ❑Home ❑Cell

Ok to speak to ❑ Emergency Contact ❑ Other: _____ **❑Medications ❑ Labs ❑Appts ❑ Billing**

Insurance Coverage (Must be filled out)

Primary Insurance Company Name: _____

ID Number: _____ **Group #** _____

Policy Holder: ❑Self ❑Other: _____ **(If Other) DOB:** _____
First M Last

Relationship to Patient: ❑ Self ❑ Spouse ❑ Other: _____ **Insured Employer:** _____

Secondary Insurance Company Name: _____

ID Number: _____ **Group #** _____

Policy Holder: ❑Self ❑Other: _____ **(If Other) DOB:** _____
First M Last

Relationship to Patient: ❑ Self ❑ Spouse ❑ Other: _____ **Insured Employer:** _____

PERSON RESPONSIBLE FOR PATIENT (if patient is under 18):

Name: _____ **DOB:** _____
First M Last

Address (if different than patient) _____

Relationship: **❑Mother ❑Father ❑ Other:** _____ **Phone:** _____ ❑Home ❑Cell **Email:** _____

Additional Information

Primary Care Doctor: _____ **Primary Care Clinic:** _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Other _____

Patient's Language: ❑English ❑_____ **Patient's Ethnicity:** ❑ Hispanic/Latino ❑Non-Hisp/Latino ❑ Other_____

Patient's Race: ❑Caucasian ❑African American ❑Asian ❑American Indian ❑Hisp/Latino ❑Other _____ ❑Unknown

AUTHORIZATION TO PAY AND RELEASE INFORMATION:

I realize it is the patient or guardian's responsibility to be aware of what is/is not covered by my insurance. The contract of insurance is between me and my insurance company, and I should clarify benefits with my insurer if any questions. I am ultimately responsible for payment of the services provided me. I hereby assign all medical and/or surgical benefits for initial and follow-up Allergy & Asthma Center (AAC) visits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to AAC. This assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Printed name of Patient/Financially Responsible: _____

Signature of Patient/Financially Responsible: _____ **Date:** _____

Allergy & Asthma Center of Southern Oregon, PC
Crisor, LLC c/o Clinical Research Institute of Southern Oregon, Inc.
3860 Crater Lake Avenue, Medford, OR 97504
Phone: (541) 858-1003 Fax: (541) 857-4499

Summary Notice of Privacy Practices**

Dear Patient,

This letter is to provide you a brief summary of our privacy policies. Please take a moment to read through this information. This is provided to continue to serve your medical needs and to comply with federal and state medical privacy rules.

As a patient of our clinics, certain information about you will be collected and kept on file at our office. This information includes: name, date of birth, social security number, insurance information, medical information including, but not limited to, medication lists and diagnostic results, and personal information such as address, phone number and employer information. With your permission we may request records from healthcare professionals that you have seen in the past. We will not disclose this information to outside parties except as authorized by yourself in our Authorization to Use and Disclose Protected Health Information (PHI) form.

You have the right to view any medical information of yours that we hold. In order to receive a copy of your information, you would need to submit a request in writing.

Through your authorization, personnel in our office may view your personal information as required. This includes our medical staff, billing staff, receptionists/schedulers, clinical research staff, and ancillary staff.

As the offices function as a research site, in addition to a medical clinic, our clinical research staff may occasionally view your information in order to determine if you may be eligible for a study. Potentially, you might be contacted regarding a research opportunity.

If you have any questions regarding your privacy rights, please ask any of our staff or contact:

Privacy Officer: Amber Emanuel
3860 Crater Lake Avenue Medford, OR 97504
541.858.1003

I would like a copy of this ***Summary Notice of Privacy Practices*** after I have signed it: Yes_____ No _____

** I would like a copy of your ***Complete Notice of Privacy Practices***: Yes _____ No _____

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Signature of Patient (or Guardian) Date

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New Patient Questionnaire

Today's Date:_____ Home Phone:_____ Cell Phone: _____

Name:_____DOB:_____ Age:_____ M F

Occupation:_____School:_____ Hobbies: _____

Personal Information: _____

OK to upload medications from your pharmacy: Y N Pharmacy: _____

✦**Current Medical Symptoms**: (Circle or Check all that Apply)

Nasal Congestion	Itchy Eyes	Day Cough	Asthma or W/Exercise	Eczema	Headache
Post Nasal Drip	Watery Eyes	Night Cough	Wheezing	Skin Rash	Snoring
Sneezing	Reddened Eyes	Productive Cough	Shortness of Breath	Hives	Sleep Problems

✦**Triggers for Symptoms**: (Circle all that Apply) Dust Trees Grasses Weeds Pets Molds/Mildew Smoke Odors Perfumes Pollution

✦**Most bothersome months**: (Circle all that Apply) **Jan Feb March April May June July Aug Sept Oct Nov Dec**

✦**Past Medical History**: (Circle all that Apply)

Chronic Skin Disease	Asthma or Emphysema	Gastric Reflux (heart burn)	Depression
Headaches	Other Lung Disease	Intestinal Problems	Anxiety
Seizures or Strokes	High Blood Pressure	Diabetes	Chronic Fatigue Syndrome
Glaucoma	Heart Disease	Thyroid Problems	Fibromyalgia
Ear Tubes or Surgery	Do you take a Beta Blocker? Y N	Hepatitis or Jaundice	
Nasal Polyps or Surgery	**Other** Conditions: _____		

✦**Food Intolerance:** None Milk Eggs Wheat Corn Shellfish Fruits Nuts Others _____

✦**Insects:** (Have you had strong reactions to) No Reactions Bees Mosquitoes Others _____

✦**Skin Contactants:** (Strong reactions to) No Reactions Poison Oak Metal Jewelry Others _____

✦**Past Surgical History:** _____

✦**Family History**: (Draw a line between the condition and the family member)

Asthma Hay Fever Eczema Hives Food Allergy Other Allergy Conditions in Family:

Mother Father Brother Sister Son Daughter Other Relatives:

✦**Home Conditions:** (Circle all that Apply)

Present Home is a: House Apartment Mobile Home Condo Other:

Present Home Has: Forced Air Heat Wood Stove Wall (Baseboard) Heater Air Conditioning

Are There: Damp Areas in Home Mold in the House Moisture under or in House Attic or Basement

Lived in present home: #yrs_____ Age of home:_____ Location:_____ Year Moved to Oregon _____

In what geographic area have you spent most of your life? _____

✦**Bedroom Products Used**: (Circle all that Apply) Mattress Waterbed Bunk Bed Other:

Feather Pillow Feather Comforter Quilt Futon Wool or Electric Blankets Carpeted Window open at Night

Do you use dust covers: Pillow Y N Mattress Y N

✦**Pet History:** Dogs: #_____ Are they ever indoors? Y N Do they sleep in Bedroom? Y N

Cats: #_____ Are they ever indoors? Y N Do they sleep in Bedroom? Y N

Other Pets or Animals:_____ Do you have exposure to barns or ranch animals? Y N

✦**Smoking History:** Did you ever smoke? Y N For how long?_____ Packs/Day?_____ Did you Quit? Y N When?

_____Does anyone smoke inside your home currently? Y N Who?

✦Are you on allergy shots: Y N Year started:_____ Maintenance Building Inhalants Venoms

✦Do you take a Beta Blocker: Y N

✦Alcohol Use: Y N Exercise: Y N Drug Use: Y N

✦**Medication Allergies or Intolerance:**_____ **Are you Aspirin Sensitive?** Y N

✦**Signature:**_____ ✦**Date:**

Allergy & Asthma Center
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Patient Medication List

Name: _____ DOB: _____ Date: _____

Drug Allergies/Intolerances: _____

Prescription Medication	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
Over-the-Counter Medication	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
What medications were stopped for Allergy Testing?	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN