Complete paperwork and fax to 480-834-6244 (if you have fax access). ***Bring paperwork with you to your appointment.***

Family Allergy Clinic *(Dr. Stuart Agren)*

Patient Information:

Last Name: ______________________ First Name: ______________________ Middle Initial: ____

Address: ______________________ City: ______________ State: ____ Zip: ______

Additional address (for seasonal visitors): ______________ City:__________ State:____ Zip:______

Email Address: ______________________________ Marital Status: ______________

Home Phone: ______________________ Cell Phone: ______________________

Social Security Number: ______________ Date of Birth: ______________ Sex: ______

Employer Name: ______________________ Employment Status: ______________

Employer Address: ______________________ City: __________State: ____ Zip: ______

In case of emergency notify: ______________________ Phone: ______________

Responsible Party Information (if different than above):

Last Name: ______________________ First Name: ______________________ Middle Initial: ____

Relationship to Patient: ____

Address: ______________________ City: ______________ State: ____ Zip: ______

Additional address (for seasonal visitors): ______________ City:__________ State:____ Zip:______

Email Address: ______________________________ Marital Status: ______________

Home Phone: ______________________ Cell Phone: ______________________

Social Security Number: ______________ Date of Birth: ______________ Sex: ______

Employer Name: ______________________ Employment Status: ______________

Employer Address: ______________________ City: __________State: ____ Zip: ______

In case of emergency notify: ______________________ Phone: ______________

If the patient is a minor: I hereby certify that I am legal guardian of the above minor and authorize the healthcare provider to perform the necessary procedures required for medical evaluation and treatment.

The patient/responsible party acknowledges that the above information is true and correct, accepts responsibility for all services rendered, and that he/she is contractually bound to pay for services rendered.

Signature: ______________________________ Date: ______________

How did you hear about us?

How did you hear about the Family Allergy Clinic?

☐ Yellow Pages

☐ Friend (Name:______________________)

☐ Newspaper/Magazine: ☐ *Beehive* ☐ *San Tan Sun* ☐ *Leisure World*

☐ Physician (Name:______________________)

☐ Website (Name: ______________________)

☐ Insurance (Co. Name:______________________)

☐ Other: ______________________

3048 East Baseline Road Suite 122 Mesa, AZ 85204 (480) 827-9945

Family Allergy Clinic
Dr. Stuart Agren

Notice of Privacy Practices

I have reviewed and am aware of the **Notice of Privacy Practices** which is also posted with the office for my review. I further understand that I can request that my Protected Health Information be limited by requesting so in writing to the Privacy Officer. I understand that this authorization meets the needs of **HIPAA (Health Insurance Probability and Accountability Act)** guidelines set forth by the Federal Government in regards to patient confidentiality.

Patient Signature: ____ Date: ____________________

(If patient is a minor) Parent/Guardian Signature: ________________________Date: ____________________

Consent for Treatment

I ______________________________ give permission to Stuart H. Agren, MD to provide care and treatment to me (or my minor/child):

Signature: ____ Date: _______________

For parent/guardian of minor:

I understand that my child cannot be treated without my presence unless I have given written consent to an adult over 18 to seek such care or treatment. In my absence the following adults over the age of 18 may seek medical attention for my minor child:

Name ____ Relationship __________________

Name ____ Relationship __________________

Patient No.____________

Allergy History Survey/Medical History

Family Allergy Clinic

Today's Date____

Patient Name____ Date of Birth: _________Gender (circle): M / F

COMPLAINTS:

Please circle the appropriate number 0-3 according to severity: **0 = absent** (no symptoms evident), **1 = mild** (symptoms present, but minimal awareness, easily tolerated), **2 = moderate** (definite awareness, bothersome, but tolerable), **3 = severe**

Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Chronic fatigue	0	1	2	3
Watery eyes	0	1	2	3	Frequent sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Learning disability	0	1	2	3
Cough	0	1	2	3	Poor memory or concentration	0	1	2	3
Wheezing	0	1	2	3	Hyperactivity	0	1	2	3
Shortness of breath, difficulty breathing	0	1	2	3	Arthritis or muscle aching	0	1	2	3
Asthma: Yes No	0	1	2	3	Food intolerance	0	1	2	3

Other symptoms or specific foods causing you problems?

____

MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never, **1 = occasionally** (several times a month or less), **2 = frequently** (several times a week), **3 = daily**

Antihistamines (Claritin, Zyrtec, Benadryl)	0	1	2	3
Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids (Prednisone)	0	1	2	3
Asthma medication (Albuterol inhaler, Singulair, Advair)	0	1	2	3
Eye drops (Patanol, antihistamine/allergy eye drops)	0	1	2	3

Other allergy-related medications ____

Does any medication give you relief of symptoms? ___________________________________

Which if any medications are you allergic to? ______________________________________

ALLERGY HISTORY:

How many months of the year do you have allergies? _________________ What year did they begin?:_________________

In what season(s) are they at their worst? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Have you been allergy tested before? ☐ Yes ☐ No

If yes, which type: ☐ Skin Prick/Puncture ☐ Serum-Specific IgE (blood draw)

Have you previously received allergy shots? __________ Allergy drops? ________If yes, when? _______________________

Do you smoke or use tobacco products? ____

List any animals you have in or around the home ____________________________________

Who else in your family has allergies? ____

Patient Name________________________________ *Allergy History Survey/Medical History (cont'd)*

PAST MEDICAL HISTORY:

Check to indicate if you have a past medical history of any of the below:

☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Cancer. If yes, what kind____
☐ Diabetes
☐ Dizziness or fainting spells
☐ Epilepsy or seizures
☐ Stroke
☐ Anaphylaxis from food or environmental allergens
☐ Depression
☐ Mental illness
☐ Thyroid problems
☐ Pneumonia
☐ Bronchitis
☐ Asthma
☐ Abnormal chest x-ray
☐ Other lung disease

Comments: ____

____

CURRENT MEDICATIONS:

List all current medications and doses:

Current medications	Doses
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Billing Policies

Family Allergy Clinic ◆ Stuart H. Agren, MD

If you do not have insurance or your service is not covered by insurance, payment is required at the time the services are rendered.

We will be happy to bill your primary medical insurance for our services. In order to do this, we require complete and accurate insurance information. All patients are responsible for their own balances. If your insurance does not pay after 60 days, we will either bill you or ask for your intervention with your insurance carrier to get the claim paid. Please complete your insurance information below:

Policyholder Name ____________________________________ Policyholder M or F (circle one)

Policyholder Address ____________________________________

City, State, Zip Code ____________________________________

Policyholder ID # ____________________________________ Group# __________________

Policyholder SS# ____________________________________

Policyholder DOB ____________________________________

Insurance Co. Name ____________________________________ Phone __________________

Claim Filing Address ____

Your payment portion/co-pay is due at the time of each visit. Payment is due immediately upon receipt of a statement from us or upon receipt of an explanation of benefits from your insurance carrier. We do not bill any third party insurances. Therefore, you are responsible for payment for those types of services.

No-Show/Cancellation Policy

If you are unable to keep your scheduled appointment, please notify us by phone at least 24 hours in advance. Patients who fail to do so will be assessed a fee of $35.

I have read and understand the above information. I accept financial responsibility for my services as outlined above. I request that payment of authorized insurance benefits be made either to me or on my behalf to Family Allergy Clinic. I authorize medical or other information needed for my claims to be released to the insurance carrier(s) or Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original.

Signature ____ Date _________________