ALLERGY AND ASTHMA CARE, P.A.

12000 ELM CREEK BLVD. #360
MAPLE GROVE, MN 55369
TEL (763) 420-1010 FAX (763) 420-3710

DATE: _____

LEGAL NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip Code

DATE OF BIRTH:	AGE:	GENDER: M ( ) F ( )	MARITAL STATUS S ( ) M ( ) SEP ( ) D ( ) W ( )
HOME PHONE:	WORK PHONE:		OTHER/PAGER/CELL PHONE:
E-MAIL ADDRESS:			
PREFER APPOINTMENT REMINDERS BY: HOME PHONE ( ) WORK PHONE ( ) CELL PHONE ( ) TEXT ( ) EMAIL ( )	IS IT OK TO LEAVE A MESSAGE ON YOUR VOICE MAIL FOR: ( ) TEST RESULTS ( ) VISIT REMINDERS		
SOCIAL SECURITY #:			
PATIENTS EMPLOYER:	PATIENTS OCCUPATION:		

PRIMARY CARE PHYSICIAN:_____CLINIC NAME: _____

REFERRED BY: _____CLINIC NAME: _____

PHARMACY NAME/PHONE #_____

IN CASE OF EMERGENCY, NOTIFY (list name, Relationship & number):

PRIMARY INSURANCE COMPANY:	PRIMARY INSURANCE COMPANY ADDRESS:	
ID OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	RELATIONSHIP TO PATIENT:	
POLICY HOLDER EMPLOYER:	POLICY HOLDER DOB:	
SECONDARY INSURANCE COMPANY:	SECONDARY INSURANCE COMPANY ADDRESS:	
ID OR POLICY #:	GROUP #:	
NAME OF POLICY HOLDER:	POLICY HOLDER DOB:	RELATIONSHIP TO PATIENT:

***IF PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION:**

NAME OF RESPONSIBLE PARTY FOR PAYMENT:	RELATIONSHIP TO PATIENT:	
ADDRESS OF RESPONSIBLE PARTY FOR PAYMENT:	PHONE # OF RESPONSIBLE PARTY FOR PAYMENT:	
MOTHER'S NAME:	DOB:	HOME PHONE:
HOME ADDRESS:		WORK PHONE:
FATHER'S NAME:	DOB:	HOME PHONE:
HOME ADDRESS:		WORK PHONE:

CO-PAYMENTS: Co-payments are due at the time of service.

FINANCIAL ARRANGEMENTS: We would appreciate your payment at the time of service. However, we understand that there may be circumstances in which you will want to make payment arrangements with our business office.

REFERRALS: If your insurance requires a referral, please obtain this referral prior to receiving care at Allergy And Asthma Care, P.A. by calling your primary physician or health plan. This will ensure your eligibility for maximum coverage by your plan. Information regarding referrals may be included on your identification card.

Please present current insurance information at the time of service. Please remember that you are ultimately responsible for any balance that your insurance plan does not cover. We cannot guarantee the amounts of coverage offered by your insurance carrier, as each policy is different.

CREDIT POLICY AND PATIENT RESPONSIBILITY: It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. It is your responsibility to know your insurance coverage. In the event your account becomes past due and is referred to an outside agency, you will be responsible for the collection costs along with any reasonable attorney fees.

To the best of my knowledge, I have completed the patient portion of this form, and I have read and understand my financial obligation and patient responsibility.

PAYMENT AUTHORIZATION/RELEASE OF RECORDS

I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO ALLERGY AND ASTHMA CARE, P.A.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS AS NECESSARY TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN OR ANOTHER PARTY OF MY DESIGNATION FROM ALLERGY AND ASTHMA CARE, P.A.

A signature must be on file in order to release your medical records to an insurance company or physician. Per state law, this authorization automatically expires in 12 months at which point we may find it necessary to have you complete another form.

I acknowledge that I have been offered a copy of Allergy and Asthma Care, PA's Notice Regarding Privacy of Personal Health Information. If I would like a copy in the future, I will ask for one.

Signature of Insured _____ **Date**_____

Responsible party (if minor) _____**Date**_____

AUTHORIZATION TO SPEAK TO SPOUSE/RELATIVE/FRIEND

If I am not available, I authorize the following individual to discuss: My Bill ( ) My Medical Care ( )

_____	_____	_____
Authorized Individual	**Relationship**	**Date**

_____	_____
Patient Signature	**Date**

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Thomas J. Helm, M.D. Pramod S. Kelkar, M.D. Amy Berglin, PA-C

Name: _____

Date of Birth: _____

Today's Date: _____

Primary physician's name: _____
Primary physician's address: _____
_____

Were you referred to us by a provider? Y/N
Referring physician's name (if different): _____
Referring physician's address: _____
_____

Patient- Please fill out this side:

The main problems are:

YES	NO		PHYSICIAN NOTES
☐	☐	Nasal congestion or sinus pressure	_____
☐	☐	Runny nose	_____
☐	☐	Itchy or watery eyes	_____
☐	☐	Sneezing	_____
☐	☐	Snoring	_____
☐	☐	Drainage down the throat	_____
☐	☐	Frequent yellow or green nasal drainage	_____
☐	☐	Ear infections in the past year? How many_____	_____
☐	☐	Sinus infections in the past year? How many_____	_____
			_____
☐	☐	Coughing (Complete page 6)	_____
☐	☐	Wheezing or shortness of breath	_____
☐	☐	Diagnosis of asthma? Age_____	_____
☐	☐	Hospitalizations for asthma? How many_____	_____
☐	☐	Emergency room visits for asthma? How many_____	_____
☐	☐	School/work missed in past year for asthma_____	_____
☐	☐	Night time symptoms of asthma? Per week_____	_____
☐	☐	Rescue inhaler use (Albuterol) Per week _____	_____
☐	☐	Prednisone courses used in the past? How many_____	_____
			_____
		Reaction to food: yes___ no_____	_____
		(Complete page 4 - one for each food)	
☐	☐	Bee sting reactions	_____
☐	☐	Rashes, eczema, hives etc (Complete page 5)	_____
☐	☐	Number of pneumonias during lifetime: _____	_____
☐	☐	Headaches	_____
☐	☐	Vomiting, diarrhea, or abdominal pain	_____
☐	☐	Transfer of allergy care from Dr. _____ __	_____
☐	☐	Continuation of allergy shots started____years ago	_____
☐	☐	Other (explain):	_____

These symptoms occur:

☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ All the time Best time of year: _____

Symptoms are made worse by:

☐ Cats	☐ Heat
☐ Dogs	☐ Cold
☐ Exercise	☐ Mowing Grass
☐ Colds	☐ Raking Leaves
☐ Cigarette smoke	☐ Drugs: _____
☐ Dusting/Cleaning	☐ Other: _____

All Current Medicines:

PHYSICIAN NOTES

	number of mg, tabs, caps, or inhaler puffs		
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____

Previous allergy or asthma medications (including OTC):

_____	☐ helped ☐ no help	_____
_____	☐ helped ☐ no help	_____
_____	☐ helped ☐ no help	_____
_____	☐ helped ☐ no help	_____
_____	☐ helped ☐ no help	_____

Past Medical History:

Birth Weight: _____Problems at Birth? YES / NO _____

Surgeries:

(Age or year)

_____ for _____ _____
_____ for _____ _____
_____ for _____ _____

Hospitalizations (other than surgery):

(Age or year)

_____ for _____ _____
_____ for _____ _____
_____ for _____ _____
_____ for _____ _____

Drug Allergies:

_____ caused _____ _____
_____ caused _____ _____

Immunization Adverse Reactions:

_____ caused _____ _____
_____ caused _____ _____

Past Allergy History: (use space at right if needed)

YES NO

☐ ☐ Previous allergy testing (If 'yes' then answer the questions below) _____
Testing by Dr._____ Year _____ _____
☐ ☐ Previous allergy shots _____
Currently on allergy injections every ___weeks _____

Do You Have:

YES	NO		YES	NO		
☐	☐	Cats	☐	☐	Cigarette smoke	_____
☐	☐	Dogs	☐	☐	Wood burning stove	_____
☐	☐	Birds	☐	☐	Damp basement	_____
Other pets: _____			☐	☐	Mold growth	_____
☐	☐	Feather pillow	☐	☐	Room air cleaner	_____
☐	☐	Down comforter	☐	☐	Whole house air cleaner	_____
☐	☐	Bedroom Carpet	Workplace: _____			_____

Family History:

	Allergies	Asthma
Mother	☐	☐
Father	☐	☐
No. of Sisters _____	☐	☐
No. of Brothers _____	☐	☐
No. of Children _____	☐	☐
Grandmother (s)	☐	☐
Grandfather (s)	☐	☐
Aunt(s)	☐	☐
Uncle(s)	☐	☐
Cousin(s)	☐	☐

Other chronic family conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, immune deficiency, cancer, diabetes etc:

_____

_____

_____

PHYSICIAN NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Social History:

Current occupation is: _____

If child, primary residence is: one home
split between homes

Activities: _____

Review of Systems: (check if present)

- ☐ Problem with Growth/Weight
- ☐ Pediatric Developmental Problems
- ☐ Skin Problems
- ☐ Blood Count Problems (anemia, etc.)
- ☐ Eye Diseases (e.g. glaucoma, cataracts)
- ☐ Hearing Problems
- ☐ Thyroid Disorder
- ☐ Lung Disease (other than asthma)
- ☐ Heart Problems or High Blood Pressure
- ☐ Stomach Upset, Heartburn/Reflux
- ☐ Bowel Disorder
- ☐ Liver Disorder
- ☐ Prostate Problem
- ☐ Urinary or Bladder Problems
- ☐ Gynecologic Problems
- ☐ Mental Health Problems
- ☐ Hormone Problems (such as diabetes, menopause, etc.)
- ☐ Bones & Joints
- ☐ Cancer
- ☐ Autoimmune Disease (e.g. Lupus, Rheumatoid Arthritis)
- ☐ HIV Infection

Other comments:

_____

_____

_____

_____

_____

_____

_____

_____

Name of person filling out this history form (print): _____

Relationship if not the patient: _____

FOOD ALLERGY QUESTIONAIRE

Please use ONE FORM PER FOOD

Name of food _____

When did you eat it last and reacted _____

How much food was eaten _____

What was the reaction _____

_____

How many minutes or hours after eating did the reaction start _____

How long did the reaction last _____

How did you treat/manage the reaction _____

_____

_____

How many times have you had the reaction _____

Did you go to the ER _____

_____

Did you try the same food again _____

Which foods are you currently strictly avoiding _____

_____

Do you have Epi-Pen or Auvi-Q _____

Do you have an Anaphylaxis Action Plan _____

What are the goals of your visit today _____

_____

_____

Hives/ Itching

How long have you had it _____ How often do you get it (weekly daily, etc) _____

How long does it lasts once it comes _____ Itching present or not _____

Do you have any pain or burning with hives _____

How does it look to you _____

_____

What body parts affected? Is it all over the body? Head/scalp? _____

_____

When it goes away, does it leave any mark behind _____ Are you under high stress _____

Do you take OTC pain killers- like ibuprofen, etc.? How often? _____

_____

What medications have you tried? Did they help? _____

_____

Did you see a dermatologist _____

_____

Did you have any blood tests done _____

_____

Do you have exposure to new contacts, environments or medications _____

_____

Do you have other symptoms like nausea, abdominal pain, fever, weight loss, etc. _____

_____

Do you get lip swelling, face swelling, throat closing? How often? _____

_____

How often have you been to the ER _____

_____

What are the goals of your visit _____

_____

_____

COUGH QUESTIONAIRE

How long have you had a cough? _____

Is the cough daytime or nighttime or both? _____

Does the cough wake you up at night? _____

Any blood or mucus? Is the cough wet or dry? _____

_____

Have you had a chest xray? If so, when and where? _____

_____

Have you had a CT of the chest? If so, when and where? _____

_____

Have you had a CT of the sinus? If so, when and where? _____

_____

Have you seen any specialists, such as Ear Nose and Throat, Pulmonology (lung) Gastroenterology?

Which ones? _____

_____

Which medications have you tried? _____

_____

Do you have heartburn/reflux issues? _____

What triggers your cough? _____

_____

Does it feel to you that the cough is coming from the throat or the chest area? _____

Are you taking any painkillers, aspirin, blood pressure or diabetes medications? _____

_____

Do you snore? _____

What are the goals of your visit today _____

_____

_____