SN Allergy Asthma Immunology

Office: 702-735-1556 | Fax: 702-737-7495
www.snallergy.com

Patient Information			
Patient's Last Name: First: MI:			Social Security Number:
Birth Date:	Age:	Sex:	Ethnicity:
Street Address:			
City:	State:	ZIP Code:	
Home Phone:	Cell Phone:	Work Phone:	
E-Mail Address:	Employer or Student Status:		
Referring Physician Name:	Primary Care Physician Name:		

Emergency Contact		
Emergency Contact Name:	Relationship:	Phone:

Primary Insurance		Secondary Insurance	
Carrier:	Cardholder's Name:	Carrier:	Cardholder's Name:
Relationship to Patient:	Cardholder's Birth Date:	Relationship to Patient:	Cardholder's Birth Date:
Cardholder's Social Security Number:		Cardholder's Social Security Number:	
Identification Number:		Identification Number:	

Pharmacy Information		
Preferred Pharmacy Name :	Phone:	Address or Intersection:

Medical Release		
I hereby authorize the release of my medical records to the following individuals:		
Name:	Relationship:	Date:
Name :	Relationship:	Date:

Office visit co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. My signature below confirms that the information provided is accurate and complete to the best of my knowledge. I consent to the performance of diagnostic procedures, examinations, and rendering of treatment that the medical provider and designated medical staff as it is deemed necessary in the medical provider's best judgment.

Signature of Patient or Responsible Party:	Date:

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Financial Policies

Because of our commitment to provide you with the highest standard of medical care, please be aware of our financial policies concerning payment of your medical expenses.

Please Review This Notice Carefully

1. Payment

Payment for services is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept Visa, MasterCard, Discover, American Express, cash, or check. The patient is responsible for all co-payment, co-insurance, or deductible amounts as assigned by the insurance carrier. If our office cannot verify insurance benefits, payment is due in full when you check-in for your appointment. If you are waiting for coverage to become effective or have no medical insurance coverage, payment in full will be expected the day you are seen. Patients must promptly inform the office of a change in insurance coverage.

2. Insurance

Your insurance is an agreement between you and your insurance company. As a courtesy to our patients, we will file insurance claims on all visits with our providers.
You should check with your insurance company to be certain of our provider status. If we are not providers for your insurance plan, you will be required to pay for your services at the time of your appointment.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the charge. Payment is due upon receipt of a statement from our office. We highly recommend that you read your insurance booklet or a copy of the insurance contract to determine your benefits.

You are required to be aware whether your insurance company required a referral and obtaining the referral before you are scheduled with one of our providers. Referrals typically have an expiration date and a limited number of visits. It is your responsibility to monitor expiration dates and number of visits.

Our providers may request certain tests and evaluations to further diagnose and treat your condition. We will assist you in making arrangements for tests and evaluations we require, but you are responsible for informing us of the facilities that are on your insurance plan. Failure to do so may result in charges to you by other facilities that your insurance does not cover.

You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable immediately. Be prepared to present your insurance card at each visit.

You will be responsible for notifying the office of a change of address, telephone number, and/or insurance information.

3. Returned checks

There is a **$35 service fee** on all returned checks in addition to the amount of the check. NSF (non-sufficient funds) checks must be redeemed with certified funds (cashier's check, credit card, money order, certified check, or cash) at or before the next office visit.

4. Past due accounts

Patients who have not made an effort to make payment arrangements to meet their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned to a collection agency will be expected to satisfy their financial obligation and pay for any future services in advance.

My signature below acknowledges that I have read Southern Nevada Allergy, Asthma & Immunology's financial policies and agree to its terms.

Patient Name:	Date of Birth:
Signature of Patient or Responsible Party:	Date:

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Patient Authorization for E-Mail and SMS Text Communication

Southern Nevada Allergy, Asthma & Immunology will use e-mail and SMS text messages for appointment reminders and emergency purposes only.

E-mail communications from Southern Nevada Allergy, Asthma & Immunology are on an un-encrypted server and the security of such e-mails cannot be guaranteed. Furthermore, Southern Nevada Allergy, Asthma & Immunology is not responsible for e-mails reaching any unintended recipients.

I will inform Southern Nevada Allergy, Asthma & Immunology of any changes of e-mail address or phone number.

I understand that I may be charged for calls or SMS texts by my wireless carrier.

My signature below acknowledges that I have read Southern Nevada Allergy, Asthma & Immunology's Authorization for E-mail and SMS Text Communication and consent to receiving such communication.

Patient Name:	Date of Birth:
Signature of Patient or Responsible Party:	Date:

SN Allergy Asthma Immunology

4445 S. Eastern Avenue Suite A Las Vegas, Nevada 89119
702-735-1556 phone 702-737-7495 fax
www.snallergy.com

Patient Name:	Date:

Review of symptoms

Please check which symptoms you are experiencing, or have experienced recently

- ☐ **NO SYMPTOMS**

Constitutional

- ☐ Fever
- ☐ Weight loss/gain
- ☐ Night Sweats
- ☐ Severe itching
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Cold intolerance
- ☐ Heat intolerance

Urinary

- ☐ Kidney stone
- ☐ Inability to urinate
- ☐ Prostate problems
- ☐ Kidney infections

Neurologic

- ☐ Fainting Spells
- ☐ Severe headaches
- ☐ Epilepsy/seizures
- ☐ Difficulty with memory
- ☐ Inability to concentrate
- ☐ Chest Pain
- ☐ Leg Swelling

Intestinal Tract

- ☐ *Nausea*
- ☐ *Vomiting*
- ☐ *Heartburn*
- ☐ *Indigestion*
- ☐ *Trouble swallowing liquids*
- ☐ *Abdominal pain*
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Gas
- ☐ Food Intolerance
- ☐ Acid or Sour taste in mouth
- ☐ Blood in stool
- ☐ Jaundice

Rheumatologic/Orthopedic

- ☐ Early morning stiffness
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Gout
- ☐ Low back pain
- ☐ Osteoporosis
- ☐ Fractured bones
- ☐ Excessive hair loss

Lungs

- ☐ Shortness of breath
- ☐ Cough
- ☐ Nighttime coughing
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Chest congestion
- ☐ Chest tightness

Skin

- ☐ Rashes
- ☐ Hives
- ☐ Eczema
- ☐ Skin tumors or growth

Ears/Nose/Throat

- ☐ Dry eyes
- ☐ Itchy eyes
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Light avoidance
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Itchy ears
- ☐ Ear infections
- ☐ Ringing in ears
- ☐ Loss of balance
- ☐ Loss of hearing
- ☐ Deviated septum
- ☐ Nose bleeds
- ☐ Post nasal drip
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Recurrent throat infections
- ☐ Loss of smell or taste
- ☐ dry mouth

Snoring

Allergic Symptoms

Please check all symptoms aggravated or precipitated that apply

	Eyes	Nose/Sinus	Chest	Digestive	Hives/Swelling	Eczema
Spring March-May	☐	☐	☐	☐	☐	☐
Summer June-August	☐	☐	☐	☐	☐	☐
Autumn Sept-Nov	☐	☐	☐	☐	☐	☐
Winter Dec-Feb	☐	☐	☐	☐	☐	☐
Freshly Cut Grass	☐	☐	☐	☐	☐	☐
Olive Trees	☐	☐	☐	☐	☐	☐
Mulberry Trees	☐	☐	☐	☐	☐	☐
Windy days	☐	☐	☐	☐	☐	☐
Location: Inside home	☐	☐	☐	☐	☐	☐
Outside home	☐	☐	☐	☐	☐	☐
At Work	☐	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐	☐
On awakening	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐
Emotional	☐	☐	☐	☐	☐	☐
Weather changes	☐	☐	☐	☐	☐	☐
House dust	☐	☐	☐	☐	☐	☐
Feather pillows	☐	☐	☐	☐	☐	☐
Road dust	☐	☐	☐	☐	☐	☐
Cats	☐	☐	☐	☐	☐	☐
Dogs	☐	☐	☐	☐	☐	☐
Birds	☐	☐	☐	☐	☐	☐
Molds	☐	☐	☐	☐	☐	☐
Air Conditioning	☐	☐	☐	☐	☐	☐
Irritant fumes/aerosols/spays	☐	☐	☐	☐	☐	☐
Smog	☐	☐	☐	☐	☐	☐
Cosmetics/perfumes	☐	☐	☐	☐	☐	☐
Tobacco smoke	☐	☐	☐	☐	☐	☐
Foods-Specify:	☐	☐	☐	☐	☐	☐
Dried fruits	☐	☐	☐	☐	☐	☐
Restaurant meals	☐	☐	☐	☐	☐	☐
Beer/Wine	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

How many ordinary colds and "flu" illnesses have you had in the last year?_____ Last 5 years? _____

How many colds and "flu" on average in the last 5 years?_____

What percent of these are complicated by:	(Circle one)						
Earache and/or decreased hearing:	0	10	25	50	75	90	100
Sinusitis-pressure, discolored drainage:	0	10	25	50	75	90	100
Bronchitis-cough with discolored sputum:	0	10	25	50	75	90	100
Asthma-chest tightness, wheezing:	0	10	25	50	75	90	100
Require antibiotics for resolution?	0	10	25	50	75	90	100

Which antibiotic(s) work(s) best for you? _____

Have you ever had the following vaccine? (Circle one) Pneumonia Prevnar Influenza

Have you had any reactions to immunizations?

- ☐ Yes
- ☐ No

Have you had any reactions to any medications?

Medication	Reaction	Current Problem	Past Problem
Penicillin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sulfa	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nose Sprays	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sedative	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pain Relievers	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hormones	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Antihistamines	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cortisone	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
X-ray dye	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Type of dwelling ☐ House ☐ Apartment ☐ Condo ☐ Dormitory ☐ Mobile/Motorhome *Location of Dwelling* ☐ Northwest ☐ Southwest ☐ Central ☐ Other *Age of Dwelling* _____ *Years of occupancy*_____ *Possible mildew/Mold* ☐ Yes ☐ No *Roaches* ☐ Yes ☐ No *Central* ☐ Heating ☐ Air conditioning ☐ Humidifier ☐ Filter type	*Bedroom* ☐ Heating ☐ Air conditioning ☐ Humidifier ☐ Filter type *Bed Mattress* ☐ *Conventional* ☐ *Water* *Age of mattress* _____ *Allergen encasement* ☐ Yes ☐ No *Pillows* ☐ Feather/Down ☐ Foam Rubber ☐ Dacron/Synthetic *Floor Covering* ☐ Carpet ☐ Wood ☐ Cement ☐ Linoleum/tile	*Indoor Animals* ☐ Cat ☐ Dog ☐ Bird ☐ Other *Outdoor Animals* ☐ Cat ☐ Dog ☐ Bird ☐ Other *Do you smoke* ☐ Yes ☐ No *Packs per day* _____ *Other Tabaco* ☐ Yes ☐ No *Amount per week*_____ *Do you live with smokers* ☐ Yes ☐ No *Relationship* _____ *Alcoholic drinks per week*_____

Family History of Allergy

Please check those that apply

	Eyes	Nose/Sinus	Chest	Digestive	Hives/Swelling	Eczema
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐

List Of Current Medications

Medication	Dose	Date Started	Condition Taken For