ALLERGY & IMMUNOLOGY SPECIALISTS
ADULT & PEDIATRIC PATIENTS

Allergy& Immunology Specialists
New Patient Registration Sheet

Personal Information

Today's Date: _____

Patient First Name: _____ Initial: _____ Last Name: _____

DOB: _____Age: _____ Social Security #: _____ E-mail: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: M F Language: ENGLISH SPANISH Other: _____ Marital Status: S M W D O

Race/Ethnicity: White_____ African American_____ Native American _____ Alaska Native _____ Asian _____

Hawaiian/Pacific Islander _____ Hispanic/Latino _____ Other _____

Occupation: _____ Retired: YES NO Retired from: _____

Employer Name: _____ Employer Telephone Number: _____

Address: _____ City: _____State: _____ Zip: _____

Financial Responsible Party Information

Name: _____ DOB: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ **DOB:** _____ **Relationship to patient:** _____

Secondary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ **DOB:** _____ **Relationship to patient**: _____

ALLERGY & IMMUNOLOGY SPECIALISTS
ADULT & PEDIATRIC PATIENTS

Allergy & Immunology Specialists

New Patient Registration Sheet

Patient Name: _____ Date: _____

Emergency Contact

Name: _____ Telephone Number: _____

Relationship to patient: _____ Date Of Birth: _____

How did you hear about Allergy & Immunology Specialists?

Physician referral? YES NO If yes, who? _____

Internet site? Yes NO If yes, what site? _____

Personal referral? YES NO If yes, who? _____

Reason for Visit

Primary reason for visit: _____ Date Symptoms started: _____

Have you been seen in Urgent Care or ER for symptoms: Yes No If Yes, when? _____

Medical History

Current	Past		Current	Past	
		Anemia			Heart Disease
		Arthritis			Hepatitis
		Asthma			Hernia
		Birth Defects			HIV/AIDS
		Bladder/Urinary Problems			Hypertension
		Bleeding Disorder			Irritable Bowel
		Broken Bones			Kidney Disease
		Cancer			Lupus
		Chest Pain			Lyme Disease
		Colitis			Prostate
		COPD			Seizures
		Depression			Skin Disorders
		Diabetes			Sleep Disorders
		Emphysema			Stomach Ulcer
		Epilepsy			Stroke
		Fibromyalgia			TB
		Goiter			Thyroid Disease
		Headaches			Valley Fever
		Hearing Impaired			Vision Impairment
		Heart Attack			Weight Loss/Gain

ALLERGY & IMMUNOLOGY SPECIALISTS
ADULT & PEDIATRIC PATIENTS

Allergy & Immunology Specialists
New Patient Registration Sheet

Patient Name: _____ Date: _____

Past Surgical History

Past Sinus Surgery YES NO If yes, when? _____

Past Tonsil Surgery YES NO If yes, when? _____

Tubes in Ears YES NO If yes, which ear? Left Right

Other Surgeries: _____

Family Medical History

	Mother	Father	Grandparent	Sibling	Child
Allergic Rhinitis					
Eczema					
Asthma					
Food Allergy					
Other					

Social History

Alcohol Use: FREQUENT SOCIAL NEVER Previous history of Alcohol use: _____

Tobacco Use: CIGARETTES CIGAR CHEW

CURRENT SMOKER: Packs per day: _____

FORMER SMOKER: Packs per day: _____

NEVER SMOKED

Caffeine Use: FREQUENT SOCIAL NEVER Type of caffeine: _____

Allergies

Known Food Allergies: YES NO If yes, what? _____

Known Pet Allergies: YES NO If yes, what? _____

Known Drug Allergies: YES NO If yes, what? _____

Current Medication

Do you currently have a Medi-port? YES NO

Medication	Strength	Frequency	Medication	Strength	Frequency

ALLERGY & IMMUNOLOGY SPECIALISTS
ADULT & PEDIATRIC PATIENTS

Allergy & Immunology Specialists

New Patient Registration Sheet

Patient Name: _____ Date: _____

Preferred Pharmacy Information

Local Pharmacy: _____Cross Streets: _____

Address: _____City: _____ State: _____ Zip: _____

Telephone number: _____ Fax number: _____

Mail order Pharmacy: _____

Address: _____ City:_____ State: _____ Zip: _____

Telephone number: _____ Fax number: _____

Office Policies

All Co-payments and account balances are due at the time services are rendered, unless other arrangements have been made.
We accept cash, check, Visa, MasterCard, Discover and American Express.
Inform the front office receptionist of any changes in demographics or insurance.
Failure to do so may lead to an account balance.
If you have an insurance plan that requires a paper referral or authorization number, it is your responsibility to make sure the referral has been completed by your primary care physician and is in our office for your scheduled appointment time. If we do not have a referral or authorization your appointment can be rescheduled.
Give at least 48 hours notice when canceling or rescheduling an appointment, so we may use that appointment for another patient.
If you are late for your appointment the doctor will be unable to see you.
There is a $50 fee for No Show appointments and same day cancellations.
There is a $25 fee for All NSF Returned Checks.
Please allow 48-72 hours for your prescription to be refilled.
PRESCRIPTIONS WILL NOT BE REFILLED OVER THE WEEKEND.

_____ _____
Patient/Guardian Signature Date

Self-Pay

I do not have health insurance and will be responsible for services rendered here at AIS. I agree to pay AIS the full and entire amount of treatment given to me or to the above named patient at each visit.

_____ _____
Patient/Guardian Signature Date

ALLERGY & IMMUNOLOGY SPECIALISTS
ADULT & PEDIATRIC PATIENTS

Allergy & Immunology Specialists
New Patient Registration Sheet

Patient Name: _____ Date: _____

Statement of Patient Financial Responsibility

AIS appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance denies any part of your claim, or if you or your physician elect to continue past your approved period, you will be responsible for your balance in full. Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old.

If you fail to make any payments for which you are deemed responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by AIS, you will responsible for all cost of collecting moneys owed, including but not limited to court costs, collection agency and/or attorney fees.

I have read the above policy regarding my financial responsibility to AIS, for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to AIS, the full and entire amount of my bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

_____ _____
Patient/Guardian Signature Date

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

_____ _____
Patient/Guardian Signature Date

Consent for Treatment and Authorization to Release Information

I hereby authorize AIS, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize AIS, and its affiliates, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

_____ _____
Patient/Guardian Signature Date

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 48 hours prior to your appointment to cancel.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged for care.

Our offices will notify you in writing, via mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

_____ _____
Patient/Guardian Signature Date

ALLERGY & IMMUNOLOGY SPECIALISTS
ADULT & PEDIATRIC PATIENTS

Allergy & Immunology Specialists

New Patient Registration Sheet

Patient Name: _____ Date: _____

QUESTIONS, CONCERNS OR COMPLAINTS

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our Privacy Officer at 623-512-4310 or by mail at 13575 W Indian School Road, Suite 200 Litchfield Park, AZ 85340.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS. To file a complaint with us, you may contact our Privacy Officer. To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCRComplaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Signature below is acknowledgment that you have read and understand this Notice.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

RELEASE OF INFORMATION

I _____ hereby authorize AIS to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I authorize AIS to contact me at:

Home Phone: _____ Work Phone: _____

May we leave a message on machine? YES_____ NO_____

Cell Phone: _____ Alternate Phone: _____

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____