

Patient Registration Form

Today's Date _____ Appointment With _____ Acct# _____

Patient Information

Legal First Name _____ M.I. _____ Last Name _____

Address _____
Street City State Zip Code

Home Phone _____ Cell _____ Work _____

Social Security Number _____ **OR** Drivers License Number _____

Primary Email _____

Birth Date _____ Gender: M / F Marital Status: Married / Single / Divorced

Referred By _____ Primary/Family Physician _____

Employer _____

Emergency Contact _____
Name Relationship Address Phone

Responsible Party (if other than patient) and Billing Information

Legal First Name _____ M.I. _____ Last Name _____

Address _____
Street City State Zip Code

Relationship to Patient _____ Social Security Number _____

Home Phone _____ Cell _____ Work _____

Drivers License Number _____ Employer _____

Primary Email Address _____

Insurance Information

PRIMARY Insurance Company _____

Address _____
Street City State Zip Code

ID Number _____ Group Number _____

Insured's Name _____ Insured's DOB _____

Insured's Employer _____ Relationship to patient _____

SECONDARY Insurance Company _____

Address _____
Street City State Zip Code

ID Number _____ Group Number _____ Insured's Name _____

Insured's DOB _____ Relationship to patient _____

Patient/Responsible Party Signature _____ Date _____

Confidential Health History

Name _____ Today's Date _____

Age _____ Date of Birth _____ Date of Last Physical Examination _____

What is your reason for today's visit? _____

Symptoms Check symptoms you currently have or have in the past year.

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Cardiovascular

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Muscle/Joint/Bone

Pain, weakness, numbness in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

Women Only

- Have you ever had any menstrual abnormalities?
- _____
- Are you pregnant?

Eye, Ear, Nose & Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

Conditions Check conditions you have or have had in the past

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migrane Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

Health and Occupation

Check which substances you use and how much:

- Caffeine _____
- Tobacco _____
- Alcohol _____
- Other _____

Check if your work exposes you to the following:

- Stress
- Hazardous Substances
- Heavy Lifting
- Other _____

Your occupation _____

Questions?

Confidential Health History

Medications List medications you are currently taking

Allergies To medications

Pharmacy Name _____ Phone _____

Family History Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					<input type="checkbox"/> Asthma, Hay Fever	
Mother					<input type="checkbox"/> Other Allergies	
Brothers					<input type="checkbox"/> Arthritis, Gout	
					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease, Strokes	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Other	

List family members that have been seen by Denver Allergy and Asthma _____

Hospitalization, Serious Illness and Injuries

Date	Hospital	Reason for Hospitalization	Outcome

Date	Serious Illness/Injury	Outcome

Have you ever had a blood transfusion? Yes / No If yes, please give appropriate dates _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____

Financial Policy Notification

Thank you for selecting us as your health care provider. We are committed to your successful treatment. The following is a statement of our Financial Policy. Please read all sections of the policy. If you have any questions or concerns, contact our business office at 303-234-1067. We require this notification to be completed annually prior to the provision of any services.

Unless you are a member of one of our contracted plans, medicaid or medicare, full payment is due at the time of service. We accept cash, checks, visa and mastercard for your convenience.

Contracted Plans

Even if Denver Allergy and Asthma Associates, P.C. is contracted with your health plan, the majority of members are still required to make some type of payment for service(s) rendered. This patient liability may be in the form of a co-payment, deductible, and/or co-insurance. If your plan has a co-payment, you will be expected to pay your co-payment prior to receiving any service including an office visit and/or immunotherapy. If you are on a high deductible plan, you will be required to pay a minimum of 50% at the time of service until we verify your deductible has been met. Co-payments, deductibles, and co-insurance are requirements of your insurance plan not Denver Allergy and Asthma Associates, P.C. We are required under our contract with these plans to collect these amounts from you.

POS and HMO Plans

Most of these plans require that you obtain a referral from your primary care physician prior to receiving any services in our office. If you do not obtain a referral from your primary care physician prior to receiving services, or a referral can not be verified by our business office, you have the option of re-scheduling your appointment or immunotherapy services. If you keep your appointment and/or receive services in our office it is with the understanding that your health plan may not pay for charges related to the services provided by Denver Allergy and Asthma Associates, P.C. and that without a referral you will be responsible for payment of all charges.

Self Pay/Non-Contracted Plans

Payment is due at the time of service unless prior financial arrangements have been made with our business office. All previous balances are expected to be paid in full prior to new services being rendered.

Divorce Situations

We look to the adult who has brought the child in for the appointment to be responsible for payment of the services which are rendered to the child. We expect the parents to be able to work out payment arrangements with one another. Our office staff will not participate in any disputes which may arise with respect to financial liability or responsibility.

Collections

Should it become necessary for Denver Allergy and Asthma Associates, P.C. to utilize the services of an outside collection agency in order to collect the amounts which are due from and owed by you, you will be held liable for any and all collection agency fees and/or attorney fees. The credit agency used by Denver Allergy and Asthma Associates, P.C. reports to all three credit bureaus.

I have read the above Denver Allergy and Asthma Associates, P.C. Financial Policy Notification and understand my financial responsibility with Denver Allergy and Asthma Associates, P.C. I hereby affix my signature as an acknowledgement of this understanding.

Print Patient Name _____

Responsible Party Signature _____ Date _____

Consent to Use and Disclose Health Information

By signing this form, you are granting consent to Denver Allergy and Asthma Associates to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: accessing our web site at www.DenverAllergy.com or by contacting our main office at 303-234-1067 and requesting a copy be sent to you. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

The physicians at Denver Allergy and Asthma Associates, P.C., participate with Western States Clinical Research in pharmaceutical/medical research studies. We believe that this is a valuable service as it not only allows us the ability to evaluate potentially new therapies for our patients, but also provides us the opportunity to remain current in our chosen field of medical science. A study/research coordinator will be allowed to review my PHI to determine if I am a potential candidate for participation. The study/research coordinator will not release my name or other personal information other than that which directly pertains to the pharmaceutical/medical research study to any third party or outside agencies.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Print Patient Name _____

Patient/Responsible Party Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Denver Allergy and Asthma Associates the use or disclosure of my Personal Health Information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations.

Specific description of PHI to be released: All test results and medical records pertaining to any testing and treatment performed by Denver Allergy and Asthma Associates, P.C.

0 Yes 0 No I am requesting my PHI (medical records) for my own use.

0 Yes 0 No I am requesting that my PHI (medical records) be sent to my health care provider:

Primary Care Physician Name (First and Last): _____

Other Medical Providers (First and Last): _____

I understand that this authorization will expire 12 months of signature date.

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my revocation will not affect any releases made or other actions taken before the date of my revocation.

Print Patient Name _____ Initials: _____

Patient/Responsible Party Signature _____ Date _____

Consent for Release of Personal Health Information

Patient's legal name _____ Acct# _____

I, _____ authorize Denver Allergy and Asthma Associates, P.C. to also use or disclose my health information as indicated by my responses below.

1. My medical condition and information may be discussed with the following persons.

DO NOT list a physician on this form.

Name _____ Relationship _____

Name _____ Relationship _____

Please circle your response.

- | | | |
|--|-----|----|
| 2. Leave a message on my phone voice mail or answering machine? | YES | NO |
| 3. Leave a message with a person who answers my home phone? | YES | NO |
| 4. Contact me at work and tell them who is calling if asked? | YES | NO |
| 5. Leave a message on my work phone voice mail or answering machine? | YES | NO |
| 6. May contact me by email at _____ | | |

Signature of patient (or patient's representative) _____ Date _____

Printed legal name of patient (or patient's representative) _____