

Trinity Allergy, Asthma and Immunology Care, P.C.
3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200
285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800
NEW PATIENT HISTORY FORM

Please answer all questions. Print and bring this form with you at the time of your appointment. Do not mail.

Name _____ Date of Birth _____ Home Phone _____

Age _____ Sex _____ Referring Doctor/ Person _____ Insurance: _____

Primary Care Physician _____ Pharmacy _____

1. Please tell us why you want to consult us. Please write down.

2. Did you undergo previous allergy evaluation and allergy injections in the past? Yes No

Where	When	Outcome

3. Only list medications that you have tried for treating allergies or asthma.

Medications that helped your allergy/asthma	Medications that did not help your allergy/asthma

4. List of all medications [prescription and over-the-counter] that you are currently taking from all providers.

Medication	Dose	Times daily	Start date	Any side effects?

5. Do you have symptoms referable to the eyes? Check all that apply. I have none

<input type="checkbox"/> Bright light bothers your eyes	<input type="checkbox"/> Get crusty secretions in the eyes	<input type="checkbox"/> Had eye surgery
<input type="checkbox"/> Eyes feel dry	<input type="checkbox"/> Rash on the eyelids	<input type="checkbox"/> Wearing glasses
<input type="checkbox"/> Eyes are itching	<input type="checkbox"/> Swelling of eyelids	<input type="checkbox"/> Wearing contact lenses
<input type="checkbox"/> Eyes are red	<input type="checkbox"/> Have glaucoma	<input type="checkbox"/> Using eyedrops
<input type="checkbox"/> Eyes are watering frequently	<input type="checkbox"/> Have cataracts	<input type="checkbox"/> Regularly following up with eye Dr.

6. Do you have any symptoms referable to the nostrils/ Sinuses? Check all that apply. I have none

<input type="checkbox"/> Itching of the nostrils	<input type="checkbox"/> Dozing off during daytime	<input type="checkbox"/> Using CPAP/BiPAP
<input type="checkbox"/> Frequent sneezing	<input type="checkbox"/> Reduced sense of smell	<input type="checkbox"/> Sinus infections 1-3 times per year
<input type="checkbox"/> Clear runny nose	<input type="checkbox"/> Frequent nosebleeds	<input type="checkbox"/> Sinus infections 4-6 times per year
<input type="checkbox"/> Discolored nasal mucus	<input type="checkbox"/> Blood stained nasal secretions	<input type="checkbox"/> Sinus infections more than 6 times per year
<input type="checkbox"/> Postnasal drip	<input type="checkbox"/> History of nasal polyps	<input type="checkbox"/> CT scan of the sinuses within the last 2 years
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> History of deviated nasal septum	<input type="checkbox"/> CT scan normal
<input type="checkbox"/> Nasal stuffiness	<input type="checkbox"/> History of cauterization of the nose	<input type="checkbox"/> CT scan abnormal
<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> History of sinus surgery	<input type="checkbox"/> ENT doctor follow-up within the last 2 years
<input type="checkbox"/> Loud snoring	<input type="checkbox"/> History of polyp surgery	<input type="checkbox"/> ENT evaluation was normal
<input type="checkbox"/> Restless sleep	<input type="checkbox"/> History of surgery for deviated nasal septum	<input type="checkbox"/> ENT evaluation was abnormal
<input type="checkbox"/> Feeling fatigued	<input type="checkbox"/> History of trauma to the face	<input type="checkbox"/> ENT Dr. recommended allergy evaluation
<input type="checkbox"/> Feeling irritable	<input type="checkbox"/> History of hole in the nasal septum	<input type="checkbox"/> ENT Dr. recommended surgery
<input type="checkbox"/> Having poor concentration	<input type="checkbox"/> Have sleep apnea	

7. Do you have any symptoms referable to the throat? Check all that apply. I have none

<input type="checkbox"/> Have bad breath	<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> Had tonsils removed
<input type="checkbox"/> Constant postnasal drip	<input type="checkbox"/> Frequent strep throats	<input type="checkbox"/> Had adenoids removed
<input type="checkbox"/> Clear throat frequently	<input type="checkbox"/> Frequent tightening of throat	<input type="checkbox"/> Had surgery for sleep apnea
<input type="checkbox"/> Frequent hoarseness of voice	<input type="checkbox"/> Frequent choking	<input type="checkbox"/> Frequent cold sores in the mouth
<input type="checkbox"/> Roof of the mouth itches	<input type="checkbox"/> Throat feels dry on waking up	<input type="checkbox"/> Frequent canker sores in the mouth

8. Do you have any symptoms referable to the ears? Check all that apply. I have none

<input type="checkbox"/> Inside of the ears itch	<input type="checkbox"/> Ear infections 4-6 times per year	<input type="checkbox"/> History of ear tubes placement
<input type="checkbox"/> Ears plugged up frequently	<input type="checkbox"/> Ear infections greater than 6 times per year	<input type="checkbox"/> History of ear surgery
<input type="checkbox"/> Ears pop frequently	<input type="checkbox"/> Reduced hearing	<input type="checkbox"/> Have/had speech impairment
<input type="checkbox"/> Frequent earaches	<input type="checkbox"/> Frequent dizziness	<input type="checkbox"/> Have received speech therapy
<input type="checkbox"/> Ear infections 1-3 times per year	<input type="checkbox"/> Ringing/buzzing in the ears	<input type="checkbox"/> Wear hearing aids

9. Check all that apply if you have headaches. I have none

<input type="checkbox"/> Headache onset less than one year	<input type="checkbox"/> Headaches predominantly affect one side	<input type="checkbox"/> Wakes up with headaches during night
<input type="checkbox"/> Headache onset 1-5 years	<input type="checkbox"/> Headaches predominantly affect both sides	<input type="checkbox"/> Family history of migraine present
<input type="checkbox"/> Headache onset greater than 5 years	<input type="checkbox"/> Nausea with headaches	<input type="checkbox"/> Had eye examination within the last one year
<input type="checkbox"/> Headaches getting worse	<input type="checkbox"/> Vomiting with headaches	<input type="checkbox"/> CT/MRI of the head done
<input type="checkbox"/> Headaches about the same	<input type="checkbox"/> Bright light bothers headaches	<input type="checkbox"/> CT/MRI of the head Normal/ abnormal
<input type="checkbox"/> Headaches getting better	<input type="checkbox"/> Loud noise bothers headaches	<input type="checkbox"/> Take Aspirin/ Tylenol/ NSAID/Pain Medication
<input type="checkbox"/> Headaches severity _____/10	<input type="checkbox"/> Get visual aura before headaches	<input type="checkbox"/> Seen by a neurologist within the last 2 years

10. Do you have any of the following chest symptoms? Check all that apply. I have none

<input type="checkbox"/> Cough	<input type="checkbox"/> Cough productive of blood	<input type="checkbox"/> Last chest x-ray was in the last one year
<input type="checkbox"/> Wheezing	<input type="checkbox"/> History of tuberculosis	<input type="checkbox"/> Chest x-ray normal/abnormal
<input type="checkbox"/> Tightness of chest	<input type="checkbox"/> History of Valley fever	<input type="checkbox"/> Last chest CT scan within the last 2 years
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> History of pneumonia	<input type="checkbox"/> CT scan of chest normal/abnormal
<input type="checkbox"/> Nighttime cough	<input type="checkbox"/> History of pneumonia	<input type="checkbox"/> Current smoker
<input type="checkbox"/> Cough following exertion	<input type="checkbox"/> History of croup	<input type="checkbox"/> Ex-smoker
<input type="checkbox"/> Cough following laughing and talking	<input type="checkbox"/> History of RSV positive bronchiolitis	<input type="checkbox"/> Exposed to secondhand cigarette smoke
<input type="checkbox"/> Cold air makes me cough	<input type="checkbox"/> History of foreign body aspiration	<input type="checkbox"/> Current on influenza vaccine for the year
<input type="checkbox"/> Cough more during spring and fall	<input type="checkbox"/> History of frequent diarrhea	<input type="checkbox"/> Current on pneumonia vaccine within the last 5 years
<input type="checkbox"/> Cough more after eating food	<input type="checkbox"/> History of emphysema/COPD	
<input type="checkbox"/> Cough productive of white mucus	<input type="checkbox"/> History of asthma	
<input type="checkbox"/> Cough productive of discolored mucus	<input type="checkbox"/> Followed by a pulmonary physician	

11. Do you have any of the following acid reflux symptoms? Check all that apply. I have none

<input type="checkbox"/> Frequent heartburn	<input type="checkbox"/> History of Vomiting fresh blood	<input type="checkbox"/> Taking acid reducing pills
<input type="checkbox"/> Frequent burping/belching	<input type="checkbox"/> History of passing black tarry stools	<input type="checkbox"/> Upper GI Endoscopy within the last 5 years
<input type="checkbox"/> Bringing up food in the mouth after eating	<input type="checkbox"/> Frequent upper abdominal pain	<input type="checkbox"/> History of H. pylori infection in the past
<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Taking NSAIDs frequently	
<input type="checkbox"/> Food getting stuck while eating	<input type="checkbox"/> Taking antacids frequently	

12. Do you have any of the following skin symptoms? Check all that apply. I have none

<input type="checkbox"/> Rash	<input type="checkbox"/> Rash affecting upper back	<input type="checkbox"/> Rash worse after menstruation
<input type="checkbox"/> Itching	<input type="checkbox"/> Rash affecting lower back	<input type="checkbox"/> Rash worse after alcohol
<input type="checkbox"/> Hives/Welts	<input type="checkbox"/> Rash affecting thighs	<input type="checkbox"/> Rash worse after dry fruits
<input type="checkbox"/> Swelling of the eyes, lips, tongue, throat, hands, feet or genitals	<input type="checkbox"/> Rash affecting legs	<input type="checkbox"/> Rash is accompanied by cough
<input type="checkbox"/> Eczema	<input type="checkbox"/> Rash affecting feet	<input type="checkbox"/> Rash is accompanied by wheezing
<input type="checkbox"/> Contact dermatitis	<input type="checkbox"/> Rash is red	<input type="checkbox"/> Rash is accompanied by difficulty breathing

<input type="checkbox"/> Dryness of skin	<input type="checkbox"/> Rash is flat	<input type="checkbox"/> Rash is accompanied by tightness of throat
<input type="checkbox"/> Skin peeling	<input type="checkbox"/> Rashes raised	<input type="checkbox"/> Rash is accompanied by swelling
<input type="checkbox"/> Skin blisters/blebs	<input type="checkbox"/> Rash is blistering	<input type="checkbox"/> Rash is accompanied by stomach cramps
<input type="checkbox"/> Rash affecting scalp	<input type="checkbox"/> Rash appears pussy and scabbed	<input type="checkbox"/> Rash is accompanied by diarrhea
<input type="checkbox"/> Rash affecting the fore head	<input type="checkbox"/> Rash is discrete	<input type="checkbox"/> Rash is accompanied by fatigue
<input type="checkbox"/> Rash affecting cheeks	<input type="checkbox"/> Rash is diffuse	<input type="checkbox"/> Rash is accompanied by fever
<input type="checkbox"/> Rash affecting ears/behind ears	<input type="checkbox"/> Rash is made worse by scratching	<input type="checkbox"/> Rashes accompanied by weight loss
<input type="checkbox"/> Rash affecting around mouth	<input type="checkbox"/> Rash is made worse by sunlight	<input type="checkbox"/> Rashes accompanied by joint symptoms
<input type="checkbox"/> Rash affecting eyelids	<input type="checkbox"/> Rash is made worse by tight clothes	<input type="checkbox"/> Family history of hives present
<input type="checkbox"/> Rash affecting neck	<input type="checkbox"/> Rash is made worse by heat and sweating	<input type="checkbox"/> Family history of swelling present
<input type="checkbox"/> Rash affecting chest	<input type="checkbox"/> Rash is made worse by hot showers	<input type="checkbox"/> Family history of hypothyroidism
<input type="checkbox"/> Rash affecting the abdomen	<input type="checkbox"/> Rash is worse in cold weather	<input type="checkbox"/> Personal history of hypothyroidism
<input type="checkbox"/> Rash affecting genitals	<input type="checkbox"/> Rash is worse in the summer	<input type="checkbox"/> Personal history of hyperthyroidism/Graves' disease
<input type="checkbox"/> Rash affecting the buttocks	<input type="checkbox"/> Rash is worse at night	<input type="checkbox"/> Personal history of goiter
<input type="checkbox"/> Rash affecting arms	<input type="checkbox"/> Rash is made worse by mechanical pressure to skin	<input type="checkbox"/> Personal history of lupus/RA
<input type="checkbox"/> Rash affecting elbows	<input type="checkbox"/> Swelling is made worse by minor trauma	<input type="checkbox"/> Personal history of liver disease
<input type="checkbox"/> Rash affecting forearms	<input type="checkbox"/> Swelling is made worse by surgery	<input type="checkbox"/> Personal history of kidney disease
<input type="checkbox"/> Rash affecting hands	<input type="checkbox"/> Swelling is made worse by dental work	<input type="checkbox"/> Personal history of diabetes mellitus
<input type="checkbox"/> History of skin warts	<input type="checkbox"/> Started new prescription medication for the rash appeared	<input type="checkbox"/> Name of the soap used
<input type="checkbox"/> History of scabies	<input type="checkbox"/> Taking aspirin	<input type="checkbox"/> Name of the shampoo used
<input type="checkbox"/> History of ringworm	<input type="checkbox"/> Taking NSAIDs	<input type="checkbox"/> Name of the lotions used
<input type="checkbox"/> History of skin yeast infection	<input type="checkbox"/> Taking fiber pills	<input type="checkbox"/> Name of the sunscreen used
<input type="checkbox"/> History of frequent cold sores in the mouth	<input type="checkbox"/> Taking laxatives	<input type="checkbox"/> Name of the detergent used
<input type="checkbox"/> History of HIV	<input type="checkbox"/> Taking herbs	<input type="checkbox"/> Using Clorox/bleach in the laundry
<input type="checkbox"/> History of sexually transmitted diseases	<input type="checkbox"/> Taking hormone pills/injections	<input type="checkbox"/> Using Bounce/Downy in the dryer
<input type="checkbox"/> History of hepatitis C	<input type="checkbox"/> Taking birth control pills	<input type="checkbox"/> Evaluation by a dermatologist within the last one year
<input type="checkbox"/> History of hepatitis B	<input type="checkbox"/> Taking suppositories	<input type="checkbox"/> Had biopsy of skin
<input type="checkbox"/> Allergic to poison ivy	<input type="checkbox"/> Taking vitamins	<input type="checkbox"/> Received steroid injection
<input type="checkbox"/> Allergic to nickel	<input type="checkbox"/> Taking supplements	<input type="checkbox"/> Received steroid pills
<input type="checkbox"/> Allergic to cosmetics	<input type="checkbox"/> Have dental implant	<input type="checkbox"/> Last date of steroid injection/pills
<input type="checkbox"/> Allergic to Neosporin	<input type="checkbox"/> Have surgical implant	<input type="checkbox"/> Dermatologist recommended allergy evaluation
<input type="checkbox"/> Allergic to latex	<input type="checkbox"/> Any changes in cosmetics before the onset of rash	<input type="checkbox"/> Dermatologist recommended patch testing
<input type="checkbox"/> Allergic to new clothes	<input type="checkbox"/> Any changes in skin and body care products before the onset of rash	
<input type="checkbox"/> Allergy to wool	<input type="checkbox"/> Using topical steroid creams	
<input type="checkbox"/> Allergic to leather	<input type="checkbox"/> Using topical Benadryl cream	
<input type="checkbox"/> Allergic to deodorants/perfumes	<input type="checkbox"/> Using topical anti-itch medication	
<input type="checkbox"/> Allergic to hair dye	<input type="checkbox"/> Using topical Neosporin	
<input type="checkbox"/> Allergic to nail polish	<input type="checkbox"/> Using emollients	
<input type="checkbox"/> Allergic to eye makeup	<input type="checkbox"/> Using sunscreens	

13. Which of the following triggers affect your allergy symptoms? Check all that apply. I have no known triggers

<input type="checkbox"/> Grasses	<input type="checkbox"/> High winds
<input type="checkbox"/> Weeds	<input type="checkbox"/> Looking at Sun
<input type="checkbox"/> Trees	<input type="checkbox"/> Heat
<input type="checkbox"/> Cat	<input type="checkbox"/> Cold
<input type="checkbox"/> Dog	<input type="checkbox"/> Cigarette smoke/wood smoke
<input type="checkbox"/> Dust	<input type="checkbox"/> Perfumes/colognes/hair sprays
<input type="checkbox"/> Dust mite	<input type="checkbox"/> Cleaning chemicals
<input type="checkbox"/> Mold/mildew	<input type="checkbox"/> Soaps and detergents
<input type="checkbox"/> Food-name	<input type="checkbox"/> Cigarette smoke/wood smoke

14. Which of the following do you have in your house? Check all that apply.

<input type="checkbox"/> Carpet	<input type="checkbox"/> Birds- how many	<input type="checkbox"/> Fake houseplants
<input type="checkbox"/> Tile	<input type="checkbox"/> Horses- how many	<input type="checkbox"/> Live houseplants
<input type="checkbox"/> Wood floor	<input type="checkbox"/> Smokers living in the house	<input type="checkbox"/> Stuffed animals in the bedroom
<input type="checkbox"/> Cats-how many	<input type="checkbox"/> Central air-conditioning	<input type="checkbox"/> Stuffed animals on the bed
<input type="checkbox"/> Dogs- how many	<input type="checkbox"/> Window air-conditioning	<input type="checkbox"/> Feather pillows/comforters
<input type="checkbox"/> Rabbits- how many	<input type="checkbox"/> Swamp cooler	<input type="checkbox"/> Grass outside
<input type="checkbox"/> Rats/ Mice- how many	<input type="checkbox"/> Recent water leaks in the house	<input type="checkbox"/> Trees outside
<input type="checkbox"/> Guniea Pigs/Hamsters-how many	<input type="checkbox"/> Presence of mold/mildew- Where?	<input type="checkbox"/> Green areas nearby

15. Do you have any allergy to foods? Answer the following please. I have none

Name of food you suspect allergy to	Nature of reaction	When
<input type="checkbox"/> Carry EpiPen <input type="checkbox"/> Member of food allergy anaphylaxis network <input type="checkbox"/> Food allergy evaluation by blood test done		<input type="checkbox"/> Wear medic alert bracelet <input type="checkbox"/> Have food allergy action plan <input type="checkbox"/> Food allergy evaluation by skin test done

16. Do you have any allergy to medications? Answer the following please. I have none

Name of the medication	Nature of reaction	When

17. Do you have any allergy to bees, wasps, yellow jackets, hornets or fireants? Answer the following. I have none

Type of insect sting (Bee, wasp, hornet etc.)	Nature of reaction	When

18. Are you allergic to latex (gloves, balloons, condoms, catheters, pacifiers, nipples etc.)? Answer the following. I have none

Type of material (gloves etc.)	Nature of reaction	When

19. Please tell us about your social history.

<input type="checkbox"/> Student	<input type="checkbox"/> Drinks alcohol frequently	<input type="checkbox"/> Not started menstruation yet
<input type="checkbox"/> Retired	<input type="checkbox"/> Used street drugs	<input type="checkbox"/> Attained menopause
<input type="checkbox"/> Homemaker	<input type="checkbox"/> Using Street drugs	<input type="checkbox"/> Had hysterectomy
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Have HIV	
<input type="checkbox"/> Disabled	<input type="checkbox"/> Have/had sexually transmitted disease	For children
<input type="checkbox"/> Current smoker	<input type="checkbox"/> Sexually active	<input type="checkbox"/> Attends school
<input type="checkbox"/> Ex-smoker	<input type="checkbox"/> Using barrier protection	<input type="checkbox"/> Attends daycare
<input type="checkbox"/> Years smoked	<input type="checkbox"/> Using birth control pill	<input type="checkbox"/> Attends baby sitter
<input type="checkbox"/> Number of cigarettes/ day	<input type="checkbox"/> Using some other method of contraception	
<input type="checkbox"/> Year quit smoking	<input type="checkbox"/> Not pregnant	
<input type="checkbox"/> Do not drink alcohol	<input type="checkbox"/> Pregnant	
<input type="checkbox"/> Drinks alcohol socially	<input type="checkbox"/> Date of last menstrual period	

20. Please tell us about your family medical history. Check all that apply.

	Father	Mother	Sibling	Grandparents	Children	Aunts	Uncles	Cousins
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/ Angioedema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Father	Mother	Sibling	Grandparents	Children	Aunts	Uncles	Cousins	Cousins
Allergy to bees/ wasps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia/ Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. If you are a child under 18 years of age, please tell us about your birth history.

<input type="checkbox"/> Born greater than 37 weeks gestation	<input type="checkbox"/> Delivery by C-section	<input type="checkbox"/> Was in NICU greater than 3 days
<input type="checkbox"/> Born less than 37 weeks gestation	<input type="checkbox"/> Required resuscitation at birth	<input type="checkbox"/> Breast fed
<input type="checkbox"/> Birth weight	<input type="checkbox"/> Was on a ventilator	<input type="checkbox"/> Bottle fed
<input type="checkbox"/> Normal Delivery	<input type="checkbox"/> Was in NICU less than 3 days	

22. Please tell us about your immunization status.

Children under 18 years	Adults
<input type="checkbox"/> Current on all recommended childhood immunizations	<input type="checkbox"/> Current on influenza vaccine for this season
<input type="checkbox"/> Not current on all recommended childhood immunizations	<input type="checkbox"/> Current on pneumococcal vaccine
<input type="checkbox"/> Current on influenza vaccine for this season	<input type="checkbox"/> Current on tetanus toxoid vaccine
	<input type="checkbox"/> Current on shingles vaccine

23. Please tell us if you suffer from any of the following medical conditions.

Medical Condition	Details
<input type="checkbox"/> Heart problem	
<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> High cholesterol/triglyceride	
<input type="checkbox"/> Diabetes mellitus	
<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Kidney disease	
<input type="checkbox"/> Thyroid problem	
<input type="checkbox"/> Stomach/intestinal problem	
<input type="checkbox"/> Female problem	
<input type="checkbox"/> Prostate problem	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Glaucoma	

Trinity Allergy, Asthma and Immunology Care, P.C.
3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200
285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

REQUEST FOR RECORDS RELEASE TO US

Physician's Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Dear Doctor: _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: _____

Birthdate: _____ Social Security Number: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the following medical records in your file. Thank you for expediting this request. Please send these records to our office address show above.

- 1. Office visit notes _____
- 2. Hospital records _____
- 3. Radiology reports _____
- 4. Laboratory test results _____
- 5. Biopsy report _____
- 6. Others _____

I hereby authorize the release of all necessary medical records to **Natarajan Asokan, M.D**
3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
I wish for them to be forwarded as soon as possible.

Patient's Signature: _____ Date: _____
(or parent if patient is a minor)

Patient's Address: _____ City: _____ State: _____ ZIP Code: _____

Signature of Witness: _____

Trinity Allergy, Asthma and Immunology Care, P.C.

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801

1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200

285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

E-Mail Consent

1. RISK OF USING E-MAIL

Dr. Asokan (Provider) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks the patient should consider before using e-mail. These include, but are not limited to the following risks:

- a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- c. E-mail senders can easily misaddress an e-mail.
- d. E-mail is easier to falsify than handwritten or signed documents.
- e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems without authorization or detection.
- g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- h. E-mail can be used to introduce viruses into computer systems.
- i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail includes agreement with the following conditions:

- a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the medical record, such as staff and billing personnel will have access to those e-mails.
- b. Provider may forward e-mails internally to provider's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- c. Although Provider will endeavor to read and respond promptly to e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
- d. If the patient's e-mail requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.

- e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- f. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
- g. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

- a. Limit the number of e-mails sent to a reasonable minimum
- b. Avoid use of his/her employer's computer and employer provided e-mail address.
- c. Inform Provider of changes in his/her e-mail address.
- d. Put the patient's name in the body of the e-mail.
- e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- f. Review the e-mail to make sure it is clear, brief and that all relevant information is provided before sending to Provider.
- g. Inform Provider that the patient received an e-mail from Provider
- h. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
- i. Withdraw consent only by e-mail or written communication to Provider.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between provider and me, and consent to the conditions outlined herein. In addition, I agree to instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

PATIENT'S or LEGAL GUARDIAN'S

SIGNATURE: _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____

Please read carefully, sign & date and submit by fax, mail or in person. Further e-mail communication is not possible without completion of this step. Ask if you have questions.



Trinity Allergy, Asthma and Immunology Care, P.C.

Natarajan Asokan, M.D.

Diplomate of American Board of Allergy & Immunology

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801

1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200

285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

www.trinityallergy.com

PERMISSION TO BILL

I authorize **Trinity Allergy, Asthma, and Immunology Care, PC** to release information regarding my care to the insurance I have on file. I certify that the information provided is true and accurate. I assign any payable benefit to **Trinity Allergy, Asthma, and Immunology Care, PC** and authorize them to submit claims on my behalf and release any information required to obtain payment for my care and treatment. I understand that I am financially liable for any non-covered service.

Printed Name: _____

Signature: _____

Date: _____

Relationship to Patient: _____

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for **Trinity Allergy Asthma and Immunology Care, P.C.** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Trinity Allergy Asthma and Immunology Care, P.C.** to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Printed Name: _____

Signature: _____

Date: _____

Relationship to Patient: _____

TRINITY ALLERGY, ASTHMA AND IMMUNOLOGY CARE, P.C.**NATARAJAN ASOKAN, M.D.**

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200
285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

WWW.TRINITYALLERGY.COM

Notice of privacy practices

The notice of privacy practices is required by the Privacy Regulations created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Please Review This Notice Carefully**1. Our commitment to your privacy**

Our Practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your IIHI

Your privacy rights in your IIHI

Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

2. If you have questions about this notice, please contact:

The Privacy Officer at: **Trinity Allergy, Asthma and Immunology Care, P.C.**, 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801

3. We may use and disclose your IIHI in the following ways:

The following categories describe the different ways in which we may use and disclose your IIHI.

Treatment. Our practice may use your IIHI to treat you. For example we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your IIHI to bill you directly for service and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

4. Use and disclosure of your IIHI in certain special circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity or location of the perpetrator).

Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain written authorization to use your IIHI for research purposes except when Internal Review Board of Privacy Board has determined that the waiver of your authorization satisfies the following:

(i) the use or disclosure involves no more than a minimal risk to your privacy based on the following:

- a. An adequate plan to protect the identifiers from improper use and disclosure;
- b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
- c. Adequate written assurances that the IIHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(ii) the research could not practicably be conducted without the waiver; and

(iii) the research could not practicably be conducted without access to and use of the IIHI.

Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

5. Your Rights Regarding Your IIHI

You have the following rights regarding the IIHI that we maintain about you:

Confidential Communication. You have the right to request that our practice communicate with you about your

health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written to the Privacy Officer at: **Trinity Allergy, Asthma and Immunology Care, P.C.**, 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801 specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate *reasonable* requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.**

Your request must describe in a clear and concise fashion:

- the information you wish restricted;
- whether you are requesting to limit our practice's use, disclosure or both; and
- to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and correct; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented (for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing to: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy

practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801. .**

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIIHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your IIIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at: **Privacy Officer, Trinity Allergy, Asthma and Immunology Care, P.C., 3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801.**

TRINITY ALLERGY, ASTHMA AND IMMUNOLOGY CARE, P.C.

NATARAJAN ASOKAN, M.D.

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801

1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200

285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

WWW.TRINITYALLERGY.COM

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of the Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

TRINITY ALLERGY, ASTHMA AND IMMUNOLOGY CARE, P.C.**NATARAJAN ASOKAN, M.D.**

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801
1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200
285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

WWW.TRINITYALLERGY.COM

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 928-681-5000. 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 Trinity Allergy, Asthma and Immunology Care, 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 have 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 made. Co-payments, deductibles, and co-insurance are requirements of your insurance plan not Trinity Allergy, Asthma and Immunology Care, 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 cannot be verified by our business office, you have the option of rescheduling 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 Trinity Allergy, Asthma and Immunology Care, 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 Trinity Allergy, Asthma and Immunology Care, 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 may be held liable for collection agency fees and/or attorney fees. The credit agency used by Trinity Allergy, Asthma and Immunology Care, P.C. reports to all three credit bureaus.

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

Print Patient Name

Patient/Responsible Party Signature

Date



Trinity Allergy, Asthma and Immunology Care, P.C.

Natarajan Asokan, M.D.

Diplomate of American Board of Allergy & Immunology

3931 Stokton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801

1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200

285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

www.trinityallergy.com

No Show Policy

I understand it is Trinity Allergy, Asthma and Immunology Care, P.C.'s policy that I will be charged \$25.00 for any no show for a scheduled appointment and failing to show up for the appointment without canceling or rescheduling the appointment at least 24 hours before the appointment time. I understand it is my responsibility to cancel or reschedule any appointment that I made with the office at least 24 hours before the scheduled appointment time. This consent is good without any time limit.

Patient's Name

Patient/Guardian's signature

Date



Trinity Allergy, Asthma and Immunology Care, P.C.

Natarajan Asokan, M.D.

Diplomate of American Board of Allergy & Immunology

3931 Stockton Hill Road, Suite D, Kingman, AZ 86409 Tel. 928-681-5800 Fax. 928-681-5801

1971 Highway 95, Bullhead City, AZ 86442 Tel. 928-758-6200

285 S. Lake Havasu Ave., Lake Havasu City, AZ 86403, Tel. 928-854-6800

www.trinityallergy.com

Medications to stop before allergy skin test appointment

Antihistamines including prescription and over the counter ones will negatively affect the outcome of skin tests. These medications have to be stopped as outlined below before you show up for a skin test appointment. As the skin tests are usually done on the same day as your first visit to our office, it is important that you consider the information below before scheduling an appointment. Remember many over the counter cold and cough medications, sleep-aids, acid reducers/ heartburn medications and eye drops contain antihistamines and have to be stopped as well before skin test appointment. If you are not sure about the nature of your medications, please check with your pharmacist. Get permission from your doctor before stopping your or your child's medications. If the antihistamine medications are not stopped required number of days before the appointment, you will not be able to complete the skin test on the day of appointment and the test may have to be postponed or other options may be considered.

❖ **Stop these oral antihistamines for 7-10 days before your appointment:**

- Alavert® (Loratadine)
- All Antihistamine Allergy Relief Eye Drops (Patanol, Pataday, Optivar, Azelastine, Zaditor etc. Call us if you are not sure). **DO NOT STOP GLAUCOMA DROPS.**
- Allegra® (Fexofenadine)
- Astelin or Astepro® nasal spray (Azelastine nasal spray)
- Astelin® (Azelastine)
- Clarinex® (Desloratadine)
- Claritin® (Loratadine)
- Dymista® nasal spray
- Loratadine (Claritin, Alavert)
- Xyzal® (levocetirizine)
- Zyrtec® (Cetirizine)

❖ **Stop these oral antihistmanines for 4 days before your appointment:**

- Actifed
- Antihist
- Atarax®, Vistaril® (Hydroxyzine)

- Azatadine (Optimine, Trinalin)
- Benadryl (Diphenhydramine)
- Bromfed
- Brompheniramine
- Cabinoxamine (Rondec)
- Chlopheniramine (Chlortrimeton)
- Clemastine (Tavist)
- Cyproheptadine (Periactin)
- Deconamine
- Desloratidine (Clarinet)
- Dimenhydrinate (Dramamine)
- Dimetapp
- Diphenhydramine (Benadryl)
- Diphenylpyraline (Hispril)
- Doxylamine (Bendectin, Nyquil)
- Drixoral
- Dura-tab
- Hydroxyzine (Atrax, Vistaril, Marax)
- Kronofed
- Meclizine (Antivert)
- Methdilazine HCl (Tacaryl)
- Naldecone
- Novafed-A
- Ornade
- Phenergan (Promethazine)
- Phenindamine (Nolamine, Nolahist)
- Pheniramine (Polyhistine D)
- Poly-Histine-D
- Promethazine HCl (Phenegan)
- Ppyrilamine (Kronohist, Rynatan)
- Rynatan
- Tavist
- Trimeprazine (Temaril)
- Trinalin
- Triprolidine (Actifed)

❖ If you are taking an **oral** antihistamine that is not listed above stop the medicine for **3-4 days** before your appointment. If you are not sure if the medicine you are taking is an antihistamine, ask your doctor or pharmacist.

❖ **Stop these medications 1-2 days before your appointment:**

- Axid® (nizatidine)
- Pepcid® (famotidine)
- Tagamet® (cimetidine)
- Zantac® (ranitidine)

❖ Some **antidepressants** can also act as antihistamines. Let us know if you are on any antidepressants before skin testing. **Do not stop antidepressants** for any reason without checking with your doctor first.

❖ **The following medications should not be stopped:**

Do not stop any of your asthma medications or inhalers.

- Cromolyn (Intal) and Nedocromil (Tilade),
- Inhaled (Beconase, Vancenese, Nasalide, Fluticasone, Nasacort, Beclovent, Vanceril, Aerobid, Azmacort, Pulmicort, Flovent, Qvar, Symbicort, Dulera, Advair)
- Oral Corticosteroids (Prednisone, Medrol)
- Pseudoephedrine
- Theophylline

Continue to take all your other medications as you normally do. Do not stop any medication without checking with your doctor first. Usually we do control skin tests first before doing full panel skin tests to ensure that your body does not have any interfering medications at the time of testing. If you are not sure about the need for stopping a medication, please call our office or the prescribing physician's office before you stop them.

If you have questions, please call our office for clarification at 928-681-5800.