

**PATIENT REGISTRATION FORM**

Acct # \_\_\_\_\_

<b>Patient Information</b>	Legal First Name _____ M.I. _____ Last Name _____
	Address _____ <small>Street City State Zip</small>
	Home Phone _____ Cell Phone _____ Email _____
	Employer _____ Work # _____
	Birth Date ____/____/____ Gender ____ M / ____ F Marital Status: ____ Married ____ Single ____ Divorced ____ Other
	Social Security # _____ or Drivers License # _____ Preferred Language ____ English ____ Other _____
	Ethnicity: ____ Hispanic/Latino ____ Non Hispanic/Latino Race: ____ Caucasian ____ African American ____ Asian ____ Other _____
	Referred by _____ Primary Physician _____

<b>Responsible Party</b>	Legal First Name _____ M.I. _____ Last Name _____
	Address _____ <small>Street City State Zip</small>
	Home Phone _____ Cell Phone _____ Email _____
	Birth Date ____/____/____ Gender ____ M / ____ F Marital Status: ____ Married ____ Single ____ Divorced ____ Other
	Social Security # _____ or Drivers License # _____
	Employer _____ Work # _____

<b>Insurance Information</b>	<b>Primary Insurance Company</b> _____
	Address _____ <small>Street City State Zip</small>
	ID Number _____ Group Number _____
	Insured Name _____ Insured DOB _____
	Insured Employer _____ Relationship to Patient _____
	<b>Secondary Insurance Company</b> _____
	Address _____ <small>Street City State Zip</small>
	ID Number _____ Group Number _____
	Insured Name _____ Insured DOB _____
	Insured Employer _____ Relationship to Patient _____

**Financial Policy:** I authorize the release of any information necessary to process claims. I request payment of benefits to Denver Allergy & Asthma Associates (DAA). I understand I am financially responsible for charges not covered by insurance.

If your plan has a co-payment, deductible and/or co-insurance you will be expected to pay your portion 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.

In the case of a divorce situation, the adult accompanying a minor patient is responsible for payment of services. Our office staff will not participate in any disputes which may arise with respect to financial liability due to legal custody agreements.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become necessary for DAA to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

I understand and agree if care at DAA requires a primary care physician referral, it is my responsibility to see that the referral is current prior to receiving care at DAA. If no referral is present in advance I agree to pay for charges at the time of services.

We accept cash, checks, Visa, Mastercard and Discover for your convenience.

**I have read the above Denver Allergy & Asthma Associates, P.C. financial policy and understand my financial responsibility.**

**Patient/Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Denver Allergy and Asthma Associates (DAA) to use or disclose my Personal Health Information (PHI) as described below. 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 regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available on our website [www.denverallergy.com](http://www.denverallergy.com).

Patient authorizes communication with family/friends regarding your **care and test results.**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Patient authorizes communication with family/friends regarding your **account and billing.**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

**Patient authorizes communication with a primary care physician or other physician (first and last name):**

1. \_\_\_\_\_ M.D.

2. \_\_\_\_\_ M.D.

**Message or responses to inquires:** (If you do not select not allowed, then you authorize DAA to contact you using the following methods)

- May we leave a message on home voicemail? \_\_\_ Not allowed
- May we leave a message with whomever answers the home phone? \_\_\_ Not allowed
- May we call your work and leave a message with the person who answers the phone? \_\_\_ Not allowed
- May we leave a message on work voicemail? \_\_\_ Not allowed
- May we contact you via Email? Email Address: \_\_\_\_\_ \_\_\_ Not allowed
- May we send out your PHI to a third party system? \_\_\_ Not allowed

The physicians at Denver Allergy & 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 with 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. \_\_\_ Not allowed

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

\_\_\_\_\_  
Signature of patient (or patient's representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed legal name of patient (or patient's representative)

# 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 \_\_\_\_\_