Allergy Institute
allergyinstitute.com

A.M. Aminian, M.D., *FAAAAI*
Asthma, Allergy, Immunology
Children and Adults

New Patient Questionaire

Name _____

What is the main reason for your visit today? _____

_____

_____

Allergy Symptoms

	yes	no		yes	no
Do you have a runny nose?	☐	☐	Do you have trouble breathing?	☐	☐
Do you have a stuffy nose?	☐	☐	Do you wheeze?	☐	☐
Do you sneeze more than usual?	☐	☐	Do you use and inhaler?	☐	☐
Do you have sinus headaches?	☐	☐	Do you cough?	☐	☐
Do you have sinus infections?	☐	☐	Do you have asthma?	☐	☐
Is your vision blurred at times?	☐	☐	Do you have a skin rash?	☐	☐
Are your eyes red?	☐	☐	Do you have itchy/dry skin?	☐	☐
Do your eyes get watery?	☐	☐	Do you have hives?	☐	☐
Is there dryness of the eyes?	☐	☐	Do you have unusual swelling?	☐	☐
Do your eyes itch?	☐	☐	Do you have abdominal pain?	☐	☐
Do you have ear infections?	☐	☐	Do you have vomiting or diarrhea?	☐	☐
Do your ears feel full or plugged?	☐	☐	Do you have food allergies?	☐	☐
			Do you have a reaction to insect bites?	☐	☐

How long have you had this (these) allergy problem(s)? years_____ months_____ days_____

How often do you have symptoms? seasonally_____ all the time_____

What medications are you currently taking for this problem? Also list any other prescription medications you are taking to treat other health problems.

_____

_____

_____

Have you had any other allergy problems in the past? yes☐ no☐

Please describe _____

_____

_____

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Medical and Social History

Do you have significant health problems or medical conditions? Please describe: _____

_____

_____

Have you had surgery? yes____ no____

If yes, please give the dates and procedures performed: _____

_____

_____

Date and result of last TB-Skin test: _____ Date of last sinus x-ray: _____

Dates of last chest x-ray:_____ Have you been tested for valley fever? yes____ no____

Do you smoke? Yes____ no____ quit____

How often do you drink alcoholic beverages? _____ How many?_____

How often do you drink soda? _____ Coffee?_____ Tea?_____

What are your hobbies?_____

_____

_____

Environmental History

Number of people living at your residence: _____

Type of dwelling: house_____ apartment_____ condominium_____ mobile home_____

Length of time you have lived there:_____

Type of heating system you have: central heat_____ space heater_____ wood stove_____

Other:_____

Type of cooling system you have: central air_____ window unit_____ water cooler_____

Floor covering: area rugs only_____ deep pile carpet_____ short pile carpet_____ wood_____ tile_____

linoleum_____ other:_____

Bedroom

Age of mattress/box spring_____ Allergy proof covers? yes_____ no_____

Pillows/comforters: feather_____ non-feather_____ Window covering: drapes_____ shades_____

washable curtains_____ blinds_____

Do you have mold problems? yes_____ no_____ If yes, where?_____

Are the pets in the home? dog_____ cat_____ bird_____ other:_____

Any pets in the bedroom? yes_____ no_____

Does anyone living with you smoke? yes_____ no_____

Is there anything in your environment that seems to make allergies worse?_____

_____

_____

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Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I was offered and/or received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that a copy of any amended Notice of Privacy Practices will be available upon request at each appointment.

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by patient, please indicate relationship:

Parent or Guardian of minor patient
Guardian or conservator of an incompetent patient
Have Power of Attorney for patient

Name and address of patient:_____
_____
_____

I authorize the following person(s) to have access to my medical information:
Name:_____ Phone Number:_____

Information authorized:
please check

☐ Medical ☐ Billing

For Office Use Only

Patient/Guardian refused_____

Reason for refusal:_____

_____

_____

_____

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Allergy Institute Policies

please initial

_____ 1. **Co-pays are always due prior to your appointment.** We accept check, cash or Visa/Mastercard. If you do not have your co-pay with you, an additional charge may apply.

_____ 2. **Missed or canceled appointments with less than 24 hours notice** are subject to a minimum fee of $45, possible dismissal of care, or referral back to primary care physician.

_____ 3. **Late/tardy arrivals** may be seen only if they can be worked back into the schedule. There also may be additional waiting time if we are able to work a tardy patient into the schedule.

_____ 4. **Refills on medication** require a 48-hour processing time.

_____ 5. **Your test results** will be reviewed at the time of your follow up appointment. Routine test results are not given over the phone by any staff member for privacy reasons.

_____ 6. **Minimize cell phone** during your visit to our office. Food and Beverages are not allowed.

_____ 7. **No perfume or cologne** for the sake of our patients who have respiratory issues.

_____ 8. **Medical records request:** We can provide a summary of your records to your physician at no charge. There is a fee for copying the entire medical record.

_____ 9. **Form fees** are charged for any paperwork completed by the doctor or nurse practitioner (no charge for the school form for the use of inhaler once per year). We require five business days for preparing any form.

_____ 10. **Insurance issues:** As a courtesy we bill your insurance for the services provided, but you are ultimately responsible for payment of any services rendered. You are responsible for any re quired referrals, or to call your insurance company for questions regarding coverage, disputes, authorizations, etc.

_____ 11. **Medical Doctors are licensed and regulated by the Medical Board of California**, 1-800-633-2322 www.mbc.ca.gov

I have read, understand, and agree to abide by the above stated policies.

_____	_____	_____
Name of Patient	Signature of Patient or Guardian	Date

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Patient's Last Name | First Name | Middle Initial

Have you ever gone by another name? ☐ yes ☐ no

If yes please indicate other name(s)

Phone Number | Email | Gender | Birthdate | Social Security Number

Marital Status: ☐ single ☐ married ☐ divorced

Patient's Address

City | State | Zip | Occupation | Employer | Employer Phone

Employer's Address | City | State | Zip

Responsible Party

Last Name | First Name | Middle Initial | Birthdate

Social Security Number | Address | City | State | Zip | Phone Number

Employer | Occupation | Employer Phone

Employer's Address | City | State | Zip

Emergency Contact

Last Name | First Name | Middle Initial

Social Security Number | Address | City | State | Zip | Phone Number

Employer | Occupation | Employer Phone

Employer's Address | City | State | Zip

Insurance Holder

Relationship | Last Name | First Name | Middle Initial

Address | City | State | Zip | Phone Number

Insurance Co. | Group # | Subscriber#

Insurance Co. | Group # | Subscriber#

Referring Doctor | Primary Doctor

I hereby assign all medical benefits, to include major benefits to which I am entitle, including Medicare, Private Insurance and any other health plans to: A.M. Aminian, M.D. I understand that I am financially responsible for all charges whether or not paid by said Insurance. I also understand that I am responsible for obtaining Authorization from my Insurance Co. or Health Plan if they require so. If no Authorization, I will be responsible for all the charges for services rendered. I hereby authorize A.M. Aminian, M.D. to release all information necessary to secure payments. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original.

Signature of Patient | Signature of Patient's Agent or Represntative | Relationship to Patient | Date