What You Need to Know About Your New Patient Appointment…

- For details on what to expect at the New Patient appointment, please go to our website and click on the About Us tab. Then click on Services and Description of Services.

- It is very important to be on time for your appointment. If you arrive late, we may not be able to see you and/or test you due to time constraints.

- Allow 1½ - 2 hours for the New Patient appointment. Your appointment will include a medical, family and environmental history, physical evaluation and any diagnostic testing you and your doctor agree are indicated.

- Fill out the forms in this packet and bring them in with you 15 minutes prior to your appointment or email them to info@nwasthma.com and please put the clinic location in the subject line.

- Wear comfortable clothing. Testing is done on arms or back, so do not wear a one piece outfit.

- Skin testing is either done on the arms or the back, so please keep these areas as clean and clear as possible. A tiny amount of the allergen(s) your doctor is suspicious of will be placed on the skin and the top layer is “scratched” to allow a very small amount of the allergen to leak in under the skin. This is a relatively painless procedure that is easily tolerated by young and old alike. It can take up to 15 minutes for the results to fully appear. In some cases testing using an intra-dermal method may also be needed. You may experience some local redness and itching for up to 24 hours after testing. Occasionally, skin test reactions last for several days. Do not be alarmed as the tests will fade away. Delayed reactions are not considered significant.

- Your doctor determines the number of tests done according to the history you have given him/her. The number of intra-dermal tests is indicated only after prick testing.

- It is important to stay off antihistamines for 3 days prior to the appointment (see back of page 1 for a list of examples). Many cough/cold remedies also contain antihistamines. Antihistamines will block the skin test reaction.

- Do NOT stop asthma medications, inhalers, nasal sprays, eye drops, prednisone/medrol or other steroid medications—or any medications taken for other conditions.

- All NW Asthma & Allergy clinics are fragrance free. Please do not wear any perfume or scented products to your appointments.

*If you have any questions concerning which medications to stop, do not hesitate to call us.*
Do not discontinue antidepressants/psychotropic medications without consulting with your prescribing physician.

Asthma medications (including inhalers, prednisone, medrol) do not affect skin testing. Do NOT stop your asthma medications!

The following is an example list of medications that must be STOPPED 3 days prior to your new patient/skin testing appointment:

**Antihistamines**

*Most Antihistamines are over the counter and therefore can go by many store brand names- ask your pharmacist or call and ask to speak to our nursing staff if you are unsure of your medications.*

(A few example of brand names are capitalized – if any questions, look for the generic name)

- azelastine (ASTELIN, ASTEPRO nasal sprays)
- brompheniramine (DIMETAPP)
- cetirizine (ALLERTEC, ZYRTEC, ZYRTEC-D)
- chlorpheniramine (CHLOR-TRIMETON, TRIAMINIC)
- desloratadine (CLARINEX)
- diphenhydramine (BENADRYL, DIPHEDRYL)
- doxylamine (NYQUIL, ALKA-SELTZER PLUS)
- fexofenadine (ALLEGRA, ALLEGRA-D)
- hydroxyzine (ATARAX, VISTARIL)
- loratadine (ALLERCLEAR, ALAVERT, CLARITIN, CLARITIN-D)
- levocetirizine (XYZAL)
- olaptadine (PATANASE nasal spray)

**Some Over-The-Counter (OTC) cold/flu medications and sleep aids contain antihistamines such as doxylamine or diphenhydramine as one of the ingredients and should be stopped 3 days prior to your appointment.**

- **Examples of cold/flu medications:** Tylenol Cold & Sinus, Nyquil, Advil Cold & Sinus
- **Examples of sleep aids:** Advil PM, Nyquil Relief, Nytol, Tylenol PM, Unisom and ZzzQuil

**Some Acid-reflux medications are antihistamines and should be stopped 24 hours prior to your appointment.**

- **Examples of acid-reflux medications:** Cimetidine (TAGAMET), Ranitidine (ZANTAC) and Famotidine (PEPCID)
Northwest Asthma & Allergy Center, P.S.

General Patient Information

This information will be considered confidential and is necessary for our files.  
Date:___/___/____

Patient’s Last Name ___________________________  First Name ________________  Middle Name ________________

Mailing Address 

City ___________________ State _______ Zip __________

Patient’s Age: ___________  Date of Birth: _______________  Month / Day / Year

Employer: _______________________________________

Race: ☐Caucasian ☐African American ☐Hispanic ☐Asian ☐Native American
☐Chinese ☐Japanese ☐Filipino ☐Native Hawaiian ☐Pacific Islander
☐Multi-racial ☐Undetermined ☐Other: _______________________

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Other or Undetermined

Best Daytime Phone #: __________________________________________

Check one: ☐Self  ☐Spouse  ☐Parent  ☐Other: ______________________

Alternate Phone #: __________________________________________

Check one: ☐Self  ☐Spouse  ☐Parent  ☐Other: ______________________

Email Address: ______________________________________________

Emergency contact person outside of the home: ______________________

Name ______________________  Phone # ________  Relationship to Patient ________

1. Do you have other family members who are seen by our providers?  If so, list name(s) & their relationship to the patient.

☐ Yes: __________________________

☐ No

2. Were you referred to us by a healthcare provider?

☐ Yes: __________________________

☐ No  ☐Yes: __________________________

☐ No

☐ Other: __________________________

☐ Yes:

Doctor’s First and Last Name ___________________________  Address ________________

Phone and / or Fax ___________________________

3. Would you like your visit sent to your primary care provider?  Please state title, such as: MD, ARNP, DO, ND.

☐ Yes, same as above. __________________________

☐ Yes, different: __________________________

☐ No  ☐Yes: __________________________

☐ No

Doctor’s First and Last Name ___________________________  Address ________________

Phone and / or Fax ___________________________

Primary Insurance Company Name: ___________________________

ID #: ___________________________  Insurance Address: ______________________

Street ___________________ City, State _______ Zip Code __________

Group or local #: ___________________________  Insurance Address: ______________________

Group or local #: ___________________________  Insurance Address: ______________________

Group or local #: ___________________________  Insurance Address: ______________________

(As It Appears on Insurance)

Subscriber’s name: ___________________________  Employer of Subscriber: ___________________________

(As It Appears on Insurance)

Subscriber’s relationship to Patient: ☐Self  ☐Spouse  ☐Other: ___________________________

Month / Day / Year ___________________________

Secondary Insurance: ☐ No  ☐ Yes:

ID #: ___________________________  Insurance Address: ______________________

Street ___________________ City, State _______ Zip Code __________

(As It Appears on Insurance)

Subscriber’s name: ___________________________  Employer of Subscriber: ___________________________

(As It Appears on Insurance)

Subscriber’s relationship to Patient: ☐Self  ☐Spouse  ☐Other: ___________________________

Month / Day / Year ___________________________

Assignment of Insurance Benefits

I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services rendered to me or my dependent.  I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference: and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Patient’s or Guarantor’s Signature ___________________________  Relationship to patient: ☐Self

☐ Parent / Legal Guardian

☐ Other: ___________________________

Print Name of Signature Above ___________________________

7-10-2014
Appointment Cancellation Policy

Your appointment time is important to everyone.

If you cannot keep your appointment for any reason, please call or email us at least 24 hours* prior to your appointment time. If you miss your appointment or cancel with less than 24 hours notice, a fee of $50 may be charged to you. You are responsible for the payment of this fee; it will not be billed or paid by your insurance company.

If you are being seen for a VCD (Vocal Cord Dysfunction) appointment, we ask for 48 hours cancellation notice, so that we can call someone on our wait list to get them in sooner. We block out a large amount of time for these types of appointments/testing. The fee for missed VCD appointments or late cancels is $100.

If a patient misses or late cancels an appointment twice within a 12 month period, their chart will be reviewed for possible discharge from the practice.

Thank you.

_________________________________________  ______________________________________
Signature                                      Account #

_________________________________________  __________________________
Printed name                                   Date

Patient name if different from signer
CONSENT TO DISCUSS MEDICAL CARE

Patient Name: (please print) __________________________ __________________________
(First, M.I., Last Name) Date of Birth: __________________________

I authorize Northwest Asthma & Allergy Center PS (NAAC) to discuss my medical information with the following individuals I have listed below. (Please print all names listed below. You do NOT need to list physicians.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

I give my permission for NAAC to leave detailed medical information at my telephone number(s):

☐ (_____) _______ - _______ _______ (_____) _______ - _______ _______

☐ Or, I do not want detailed medical information left on any of my #’s.

(Signature of Patient, Parent or Legal Guardian) __________________________
(Printed name of signature above) __________________________
(Date signed) __________________________

CONSENT FOR TREATMENT OF A MINOR

Date: __________________________

I, __________________________, the parent or legal guardian of my child, __________________________,
(Please print your name) (Patient’s name, please print)
(Date of birth)

authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required and I waive my right of prior informed consent to such treatment. This authorization shall remain effective unless revoked in writing by me.

(Signature of Parent/Guardian) __________________________
(Date signed) __________________________

NOTE: For your child’s safety, Northwest Asthma and Allergy Center requires all children under the age of 16 to be accompanied by an adult (18 years or older) for the duration of their visit when receiving allergy shots or being seen by the physician.

6.10.2014
Thank you for choosing Northwest Asthma & Allergy Center for your medical care.

**Financial Responsibility:**
Patients must arrive at their scheduled appointment with their insurance card, photo ID and insurance copay if applicable. Copays required by a patient’s insurance plan must be paid at the time of the appointment. A $10 service fee may be applied when the copay is not paid at the time of the appointment. This service fee is in addition to the copay amount owed.

If a patient’s insurance plan requires a referral to be seen at a specialist’s office, it is the patient’s responsibility to ensure a referral is on file and is current for all dates of service. If no referral is on file, the patient may be responsible for the total amount for the services provided. Patient balances must be paid within 30 days of receipt of the patient statement.

The patient is ultimately responsible for all charges associated with their medical care regardless of insurance coverage. We do not check your insurance benefits for deductibles or co-insurance amounts. If you have concerns about patient responsibility beyond your co-pay for the office visit, contact your insurance company. NAAC participates in a large variety of insurance plans. NAAC accepts assignment and is a participating provider with Medicare. If the patient has an insurance plan coverage that NAAC does not participate in, a claim will be filed to the insurance as a courtesy.

Patients who do not have insurance coverage (private pay) are required to pay a minimum deposit of $200/$150 (new or established patient) at the time of their appointment. This deposit amount does not cover the entire cost of the services provided. The balance remaining will be billed to the patient and is payable within 30 days of receipt of the patient statement.

**Late Cancellation and No Show Fee Policy:**
A late cancellation or no show fee of $50 ($100 for VCD appts) will be charged to all patients who do not provide 24 hour notification to cancel a scheduled appointment or for patients who miss or no show their scheduled appointment. If a patient cancels or no shows an appointment two times within a 12 month period, they may be discharged from the practice.

**Treatment of a Minor (under the age of 18):**
If a patient is a minor (under the age of 18), a parent/guardian or parents/guardians of the child must be present at the time of the new patient appointment. No exceptions. The parent is responsible for the patient’s copay and referral needs or other insurance requirements at the time of service for all scheduled appointments. NAAC must have a signed consent form on file or a note signed by a parent or legal guardian if a parent or legal guardian does not accompany a minor to their future appointments.

**Consent to Discuss Medical Care:**
Parents/Guardians of minor patients and all legal aged patients (18 years or older) will be asked to complete a Consent to Discuss Medical Care form. Completion of this form provides authorization for staff to discuss medical care with those individuals listed.

**Health Insurance Portability and Accountability Act (HIPAA):**
I understand NAAC will use and disclose health information about me in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices. I also understand NAAC is not required by law to agree to such requests. My signature below acknowledges I am aware of my rights in accordance to HIPAA.

By signing this form, I acknowledge that I understand the policies as outlined above. In addition, my signature permits NAAC to file claims to my insurance (if applicable). I also understand I accept financial responsibility for all services rendered regardless of insurance coverage.

________________________________________________________  __________________________________
(Signature of Patient, Parent/Guardian)  (Patient Name If Different From Signer)

________________________________________________________  __________________________________
(Printed Name)  

Date: ________________________________  ________________________________

6.10.2014
PATIENT HISTORY

REASON FOR APPOINTMENT
1.
2.
3.

Other health concerns:

Onset of problem: infancy childhood teens age or year

Areas lived:

AREAS AFFECTED: □ Eyes □ Ears □ Nose □ Throat □ Lungs □ Digestive □ Skin

SYMPTOMS: (circle ALL that apply)
- Itching/Teasing Eyes
- Sneezing
- Runny Nose
- Congestion
- Snoring
- Postnasal Drip
- Throat
- Clearing
- Infection
- Bad Breath
- Cough
- Bronchitis
- Tightness
- Wheezing
- Shortness of Breath
- Abdominal Pain
- Heartburn
- Vomiting
- Diarrhea
- Hives
- Swelling
- Rash
- Eczema
- Pain

WHAT FACTORS CAUSE OR WORSEN SYMPTOMS?: (circle ALL that apply)
- Spring, Summer, Fall, Winter
- Cold Air, Heat, Exercise
- Outside, In House, Daycare, School, 2nd Home
- Colds/Upper Respiratory Infections
- Cats, Dogs, Feathers/Down
- Smoke/Pollution, Fumes/Chemical Odors
- Other Animals: __________________________
- Weather Changes
- Trees, Grass, Weeds, Mold/Mildew, Dust
- Sun, Soaps/Detergents, Cosmetics, Clothing
- Insect Stings: □ Sting □ Bite Type of reaction: __________________________
- Drug Reactions: Antibiotics, Aspirin, Other Anti-inflammatory (e.g., ibuprofen)
- Type of reaction: __________________________
- Foods: __________________________
- Latex reactions:

PREVIOUS ALLERGY EVALUATION AND MEDICATIONS PRESCRIBED:
- Treatments Tried: ______________________ Pills: ______________________
- Nasal sprays: ______________________ Inhalers: ______________________
- Allergy shots - Years ______________________ Steroids (prednisone) ______________________

CURRENT AND “AS NEEDED” MEDICATIONS from all physicians (including over-the-counter products like aspirin, antihistamines, and vitamins):

DRUG ALLERGIES:

PAST MEDICAL HISTORY:
- Hospitalizations: ______________________ ER visits: ______________________
- Surgery: ______________________ Immunization up to date?: Yes / No

CHRONIC MEDICAL PROBLEMS, PAST AND PRESENT: (circle ALL that apply)
- Cancer
- GERD (acid reflux)
- Kidney Disease
- Positive Tuberculin Test/TB
- Diabetes
- Heart Disease
- Migraine Headaches
- Sinus Infections
- Ear Infections
- Hepatitis
- Osteoporosis
- Thyroid Disease
- Epilepsy/Seizures
- High Blood Pressure
- Pneumonia
- Ulcers
- Other ______________________

FOR CHILDREN < 2 YRS.:
- Birth History: Birth Weight __________________ Complications __________________
- Breast Feeding __________________ Formula (type) __________________

TURN OVER PLEASE ➔➔➔
**FAMILY HISTORY:**

<table>
<thead>
<tr>
<th>Nasal Allergy</th>
<th>Asthma</th>
<th>Skin Allergy</th>
<th>Food Allergy</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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</tr>
</tbody>
</table>

**SOCIAL HISTORY:**

<table>
<thead>
<tr>
<th>Marital status:</th>
<th>Single</th>
<th>Married / Partner</th>
<th>Divorced</th>
<th>Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Children &lt;18 yrs:</td>
<td># of siblings</td>
<td>daycare</td>
<td>preschool</td>
<td>school</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current occupation:</th>
<th>Hobbies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cigarette / Marijuana / Cigars / Chew Tobacco:</th>
<th>Current - How much per day?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Started when?</td>
<td>Attempts to quit?</td>
<td></td>
</tr>
<tr>
<td>Past - How much/day?</td>
<td>When did you quit?</td>
<td></td>
</tr>
<tr>
<td>Alcohol use - Drinks/day:</td>
<td>Drug use:</td>
<td></td>
</tr>
</tbody>
</table>

**ENVIRONMENTAL HISTORY:**

<table>
<thead>
<tr>
<th>Current Home:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location: city / rural</td>
<td>Outdoor factors (trees / fields / swamps)</td>
</tr>
<tr>
<td>How old?</td>
<td>house</td>
</tr>
<tr>
<td>Heat/Ventilation: baseboard</td>
<td>wall units</td>
</tr>
<tr>
<td>Filter? None fiberglass HEPA electrostatic air cleaner;</td>
<td>How often changed/cleaned?</td>
</tr>
<tr>
<td>Mold/Mildew: basement laundry kitchen</td>
<td>bath humidifier / dehumidifier</td>
</tr>
<tr>
<td>Rooms with carpeting:</td>
<td>bedroom</td>
</tr>
<tr>
<td>Patient's Bedroom: Mattress:</td>
<td>Sleep Comfort</td>
</tr>
<tr>
<td>Pillows:</td>
<td>synthetic</td>
</tr>
<tr>
<td>Pets: How many?</td>
<td>☐ Cat(s)</td>
</tr>
<tr>
<td>Smokers in home:</td>
<td>none</td>
</tr>
</tbody>
</table>

**REVIEW OF SYSTEMS** (items in bold are for children):

Do you CURRENTLY have or have you RECENTLY had any of the following? Circle “none” if negative.

<table>
<thead>
<tr>
<th>none</th>
<th>Eyes</th>
<th>blurry vision</th>
<th>itchy eyes</th>
<th>red eyes</th>
<th>tearing</th>
<th>change in vision</th>
<th>glaucoma</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td>ENT</td>
<td>hearing loss</td>
<td>ringing in ears</td>
<td>nose bleeds</td>
<td>nasal drainage</td>
<td>sinus problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Respiratory</td>
<td>cough</td>
<td>shortness of breath</td>
<td>wheezing</td>
<td>history of pneumonia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Heart</td>
<td>chest pain</td>
<td>foot swelling</td>
<td>heart murmur</td>
<td>fast heart rate</td>
<td>palpitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Digestive</td>
<td>abdominal pain</td>
<td>constipation</td>
<td>diarrhea</td>
<td>heartburn / indigestion</td>
<td>nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Skin</td>
<td>acne</td>
<td>dry skin</td>
<td>itching</td>
<td>rash</td>
<td>sores</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Musculoskeletal</td>
<td>joint swelling</td>
<td>joint pain</td>
<td>muscle aches</td>
<td>back pain</td>
<td>arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Neurological</td>
<td>behavior problems</td>
<td>fainting</td>
<td>learning problems</td>
<td>headaches/migraines</td>
<td>daytime sleep</td>
<td>dizziness</td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Endocrine</td>
<td>cold intolerance</td>
<td>heat intolerance</td>
<td>excessive thirst</td>
<td>night sweats</td>
<td>weight gain or loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Blood/Lymph</td>
<td>anemia</td>
<td>swollen lymph node</td>
<td>unusual bleeding or bruising</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Urinary</td>
<td>painful urination</td>
<td>frequent urination</td>
<td>frequent infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Psych/Social</td>
<td>fatigue</td>
<td>anxiety</td>
<td>depression</td>
<td>drug/alcohol</td>
<td>stress</td>
<td>sleep problems</td>
<td></td>
</tr>
<tr>
<td>none</td>
<td>Reproductive</td>
<td>pregnancy</td>
<td>planning pregnancy?</td>
<td>fertility problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Reviewed with patient by MD ____________________________ Date ________________

Revised 2/15
Please see our website for detailed directions: [www.nwasthma.com](http://www.nwasthma.com)

Do not use GPS, Google or Mapquest where noted below, as it will take you to the wrong place

## Clinic Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everett</td>
<td>Silver Lake Pavilion, 10333 – 19th Ave SE, Suite 105, Everett, WA 98208</td>
<td>425.385.2802</td>
<td>425.337.7967</td>
</tr>
<tr>
<td>Issaquah</td>
<td>Highmark Building, 1740 NW Maple St, Suite 211, Issaquah, WA 98027 (do NOT use GPS/Google/Mapquest)</td>
<td>425.395.0175</td>
<td>425.395.0176</td>
</tr>
<tr>
<td>Renton</td>
<td>IDC Building, 1412 SW 43rd St, Suite 210, Renton, WA 98057 (do NOT use GPS/Google/Mapquest)</td>
<td>425.235.1716</td>
<td>425.277.5479</td>
</tr>
<tr>
<td>Richland</td>
<td>108 Columbia Pt Dr, Richland, WA 99352</td>
<td>509.946.0189</td>
<td>509.946.0264</td>
</tr>
<tr>
<td>Seattle</td>
<td><em>Please note this is the Seattle address as of April 2012</em> Northgate Executive Center II, 9725 – 3rd Ave NE, Suite 500, Seattle, WA 98115</td>
<td>206.527.1200</td>
<td>206.523.0724</td>
</tr>
<tr>
<td>Yakima</td>
<td>3901 Creekside Loop, Suite 100, Yakima, WA 98902</td>
<td>509.966.3259</td>
<td>509.966.0191</td>
</tr>
</tbody>
</table>
ASTHMA, Inc.
A Non-Profit Asthma & Allergy Clinical Research

Are You Interested in Learning More About Asthma and Allergy Related Research Studies?

The physicians at the Northwest Asthma and Allergy Center (NAAC) have maintained a longstanding commitment to clinical research studies. Since 1972 the NAAC physicians have been involved in more than 500 FDA approved clinical trials through their non-profit research arm called the ASTHMA Inc Clinical Research Center. ASTHMA Inc is located in the Northgate office and currently enrolling for multiple asthma and allergy clinical studies.

ASTHMA Inc Clinical Research Center and NAAC are members of Seattle Food Allergy Consortium (SeaFAC). To learn more about SeaFAC and to sign up to be notified of upcoming food allergy research studies, visit our website at www.seafac.org.

If you are interested in learning more, please list your telephone number and/or email address, so we may contact you.

Name: _______________________________________________________

Telephone number: ____________________________________________

Email Address: ________________________________________________

Preferred contact method:

○ Phone  ○ Text  ○ Email

For more information, please check our website at:

www.asthmainc.org
www.seafac.org

Northgate Executive Center II
9725 Third Avenue NE, Suite 500
Seattle, WA  98115
Phone: 206.525.5520 • Fax: 206.524.6549 • www.asthmainc.org
Associated with Northwest Asthma & Allergy Center