



**Northwest Asthma
& Allergy Center, P.S.**

Appt Date & Time: _____

Clinic Location: _____

www.nwasthma.com

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.
- 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. 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)
olopatadine (PATANASE nasal spray)

ALSO: Over-the-counter (OTC) cold/flu medications and OTC sleep aids often contain antihistamines as one of the ingredients and should be stopped 3 days prior to your appointment.

ALSO: Some Acid-reflux medications are antihistamines, including Cimetidine (TAGAMET), Ranitidine (ZANTAC) and Famotadine (PEPCID). These should be stopped 24 hours prior to your appt.

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 Date of Birth: _____
Month / Day / Year

Age: _____ Sex: Male Female

Race: Caucasian African American Hispanic Asian Native American

Chinese Japanese Filipino Native Hawaiian Pacific Islander

Multi-racial Undetermined Other: _____

Email Address: _____

Best Daytime Phone #: (____) _____ - _____ **Please Circle One:**
(Mobile, Home or Work)

Self Spouse Parent Other: _____

Alternate Ph. #: (____) _____ - _____ (Mobile, Home or Work)

Self Spouse Parent Other: _____

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 patient.

No Yes: _____

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

No Yes: _____
Doctor's Name _____ Address _____ Phone and / or Fax _____

2b. We send a copy of today's visit to your referring provider.

Send future visits? No Yes

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

No Yes: _____
Doctor's Name _____ Address _____ Phone and / or Fax _____

3b. Send future visits? No Yes

Insurance Information

Primary Insurance Company Name: _____

ID #: _____ Insurance Address: _____
Street City, State Zip Code

Group or local #: _____

Subscriber's name: _____ Employer of Subscriber: _____
(As It Appears on Insurance)

Subscriber's Date of Birth: _____ Subscriber's relationship to Patient: Self Spouse Other: _____
Month / Day / Year

Secondary Insurance: No Yes: _____

ID #: _____ Insurance Address: _____
Street City, State Zip Code

Group or local #: _____

Subscriber's name: _____ Employer of Subscriber: _____
(As It Appears on Insurance)

Subscriber's Date of Birth: _____ 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

Print Name of Signature Above _____ Other: _____

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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.

Patient Name

Account #

Signature

Date

Printed name if different from patient



Patient Name: (please print): _____
(First, M.I., Last Name)

Date of Birth: _____

Patient's Account No: _____

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.)

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

I give my permission for NAAC to leave detailed medical information at these telephone numbers:

- () _____ - _____ () _____ - _____
- I do not want detailed medical information left on any of my #'s.

(Signature of Patient, Parent or Legal Guardian)

(Date signed)

(Printed name of signature above)

CONSENT FOR TREATMENT OF A MINOR

Date: _____

I, _____, the parent or legal guardian of my
(Please print)

child, _____, _____
(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 12 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.

NORTHWEST ASTHMA & ALLERGY CENTER (NAAC)

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. 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 late 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 (or 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 to ensure patient copays due at the time of service, referral needs or other insurance requirements are covered for the minor child at 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 guardian does not accompany a minor to their appointment.

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.

(Patient Name)

Date: _____

(Signature of Patient, Parent/Guardian)

(Printed name of Signer)



Empty rounded rectangular box for patient information.

PATIENT HISTORY

Name: _____ DOB _____

Informant: Patient Parent Relative

REASON FOR APPOINTMENT

- 1.
2.
3.

Other health concerns: _____

Onset of problem: infancy childhood teens age _____ or year _____

Areas lived: _____ Time in Northwest: _____

AREAS AFFECTED: Eyes Ears Nose Throat Lungs Digestive Skin

Table with 7 columns: SYMPTOMS (circle ALL that apply), Itching/Tearing 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

DOCTOR'S NOTES

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:

When? _____ Where? _____ MD? _____ Skin tests? _____
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: _____

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: Nasal Allergy Asthma Skin Allergy Food Allergy Other:

Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

DOCTOR'S NOTES

SOCIAL HISTORY:

Marital status: Single Married / Partner Divorced Widowed

For Children <18 yrs.: # of siblings _____ daycare preschool school home school

Current occupation: _____ Hobbies _____

Smoke/Chew Tobacco: *Current* - How much per day? _____

Started when? _____ Attempts to quit? _____

Past - How much/day? _____ When did you quit? _____

Alcohol use - Drinks/day: _____ Drug use: _____

ENVIRONMENTAL HISTORY:

Current Home:

How old? _____ house apartment trailer condo own/rent How long here? _____

Location: city suburb country Outdoor factors (trees/fields/swamps) _____

Heat/Ventilation: baseboard wall units radiator wood stove space heater radiant

Forced air (furnace heat pump) air conditioner (window/central)

Filter? none fiberglass HEPA electrostatic air cleaner

How often changed or cleaned? _____ Ducts cleaned? _____

Mold/Mildew: basement laundry kitchen bath humidifier/dehumidifier

Rooms with carpeting: bedroom living room TV room How old? _____

Patient's Bedroom: *Mattress:* regular Sleep Comfort Tempur-Pedic

Pillows: synthetic feather/down *Comforter:* washable down How many stuffed animals? _____

Pets: How many? Cat(s) _____ Dog(s) _____ Other: _____

Smokers in home: none patient mother father spouse/partner child packs/day _____

REVIEW OF SYSTEMS:

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

none	General	fatigue	fever	night sweats
none	Eyes	blurry vision change in vision	itchy eyes glaucoma	red eyes tearing
none	ENT	hearing loss sinus problems loss of smell	ringing in ears sore throat nasal polyps	nose bleeds hoarseness snoring
none	Respiratory	cough	shortness of breath	wheezing history of pneumonia
none	Heart	chest pain	foot swelling	heart murmur fast heart rate palpitations
none	Digestive	abdominal pain vomiting	constipation diarrhea	heartburn/indigestion nausea blood in stool
none	Skin	acne hives	dry skin swelling	itching hair loss rash sores psoriasis
none	Musculoskeletal	joint swelling	joint pain	muscle aches back pain arthritis
none	Neurological	behavior problems fainting	learning problems headache/migraines	daytime sleep seizures dizziness memory loss
none	Endocrine	cold intolerance	heat intolerance	excessive thirst weight gain or loss
none	Blood/Lymph	anemia	swollen lymph node	unusual bleeding or bruising
none	Urinary	painful urination	frequent urination	frequent infections
none	Psych/Social	anxiety	depression	drug/alcohol stress sleep problems
none	Reproductive	pregnancy	planning pregnancy?	fertility problems



Northwest Asthma & Allergy Center, P.S.

Please see our website for detailed directions: www.nwasthma.com
Do not use GPS, Google or Mapquest where noted below, as it will take you to the wrong place

Clinic Locations

Everett

Sliver Lake Pavillion
10333 – 19th Ave SE, Suite 105
Everett, WA 98208

Phone: 425.385.2802
Fax: 425.337.7967

Issaquah

Highmark Building
1740 NW Maple St, Suite 211
Issaquah, WA 98027
(do NOT use GPS/Google/Mapquest)

Phone: 425.395.0175
Fax: 425.395.0176

Mount Vernon

1801 E Division
Mount Vernon, WA 98274

Phone: 360.424.4410
Fax: 360.424.0749

Novelty Hill (Redmond Ridge)

Please note there are 2 Redmond locations
22635 NE Marketplace Dr, Suite 110
Redmond, WA 98053
(do NOT use GPS/Google/Mapquest)

Phone: 425.898.2000
Fax: 425.898.2008

Redmond- Main

Please note there are 2 Redmond locations
8301 – 161st Ave NE, Suite 308
Redmond, WA 98052

Phone: 425.885.0261
Fax: 425.883.8474

Renton

IDC Building
1412 SW 43rd St, Suite 210
Renton, WA 98055
(do NOT use GPS/Google/Mapquest)

Phone: 425.235.1716
Fax: 425.277.5479

Richland

108 Columbia Pt Dr
Richland, WA 99352

Phone: 509.946.0189
Fax: 509.946.0264

Seattle

Springbrook Professional Center
4540 Sandpoint Way NE, Suite 200
Seattle, WA 98105

Phone: 206.527.1200
Fax: 206.523.0724

Yakima

3901 Creekside Loop, Suite 100
Yakima, WA 98902

Phone: 509.966.3259
Fax: 509.966.0191