OKLAHOMA INSTITUTE of ALLERGY ASTHMA & IMMUNOLOGY

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status ❑ Single ❑ Married ❑ Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ❑ M ❑ F

Street address:	Social Security Number :	Cell phone:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone:

How did you hear about our Clinic?

❑ Referred by Doctor ❑ Family ❑ Friend ❑ Vehicle ❑ Social Media ❑ Billboard ❑ Other _____

Patient Email Address:

Pharmacy Name: Pharmacy Address: Pharmacy Phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #:

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address(city,state,zip):	Employer phone #:

Is this patient covered by ❑ Yes ❑ No insurance?

Please indicate primary insurance

❑ BC/BS ❑ United Health ❑ Aetna ❑ Cigna ❑ Coventry ❑ Wed TPA ❑ Other _____

Subscriber's name:	Subscriber's SSN:	Birth date:	Group #:	Member ID:	Co-pay: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Member ID:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell phone:	Work phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize OIAAI or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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HIPAA CONSENT

My signature on this form indicates that I want to receive appointment confirmation via text and have received the Notice of Privacy Practice for the Oklahoma Institute of Allergy Asthma & Immunology located on last 3 pages.

If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the Notice of Privacy Practices. I also consent to the use and disclosure of my protected health information for my treatment, payment and operational use.

Name:	Signature:	Date:
Name of Personal Representative (if different from above)		
Name:	Signature:	Date:
Relationship to patient:		

Release of information to Insurance

I authorize release of any information concerning me (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to the doctor.

Signature:	Date:

Authorization for Release of Medical Information to others

Disclosures to friends and/or family members I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to all listed below:

Name 1: Name 2:

Name 3: Name 4:

Patient Acknowledgment

Signature:	**Date:**

Financial Agreement

No Show / Cancellation Fees will apply to patients if appointment is cancelled without a 24hour notice to the office. Chart #: _____

There will be a $125.00 fee for established patient appointments and a $200.00 fee for New Patient appointments.

repeated cancellation or missed appointments will result in loss of future appointment privileges

Credit Card Appointment Reservation form:

Credit Card #		Card Type
Expiration Date	CC Security Code (3 dig)	Zip Code
Card Holder Name	Card Holder signature	

Payment is due at time of service.
Allergy Serum must be paid for prior to mixing.
Patient is subject to prior Authorization fees for medication.
Patient is responsible for all charges. If patient account balance is not paid in full within 30 days we reserve the right to send the account to a collections agency. If the account goes to a collection agency 30% of the balance will be added to the account. We offermultiple forms of payment: Cash, Check ($50 return check fee), VISA, MasterCard, Discover, and Care Credit.

By signing the Financial Agreement I agree to the terms of OIAAI policy

Name:	Signature:	Date:

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New Patient Questionnaire Patient Name:

Please read carefully and complete the questionnaire. Please print legibly. Answers should be your own thoughts and experiences. Not just based off previous testing. Please circle or fill in the blanks accordingly. All information will be considered confidential.

Current Medications:
Please list **ALL** medications currently taking and the dosage including OTC medications, or provide a list so we may scan into your chart.

Allergies: Please list all the apply and what type of reaction

Medications:

Foods:

Previous Allergy Evaluation

When:	**Who:**	
Have you had allergy shots? ☐ Yes ☐ No	**Were they helpful?** ☐ Yes ☐ No	**How long were you on them?**

Nasal History

☐ Itching	☐ Sneezing	☐ Post Nasal Drip	☐ Congestion	☐ Loss of smell
☐ Snoring	☐ Sinus Infection	☐ Nose surgery	☐ Nose Trauma	☐ Runny Nose

What month's symptoms are the worst?

☐ Jan	☐ Feb	☐ Mar	☐ Apr	☐ May	☐ Jun
☐ Jul	☐ Aug	☐ Sep	☐ Oct	☐ Nov	☐ Dec

Nasal Triggers

☐ Cleaning products	☐ Detergents	☐ Cooking odors	☐ Perfume/ cologne	☐ Tobacco Smoke
☐ Powder	☐ Moth balls	☐ Motor fumes	☐ Paint lacquer	☐ Wax
☐ Insect spray	☐ Chemicals	☐ Fertilizers	☐ Ammonia	☐ Room deodorants

☐ Bleach	☐ Glue	☐ Soap	☐ Shampoo	☐ Shaving cream
☐ After shave	☐ Spray deodorant	☐ Hair spray	☐ Hair dye	☐ Hand lotions
☐ Nail polish	☐ Dogs	☐ Cats	☐ Equine	☐ Cattle
☐ Rodents	☐ Hot	☐ Cold	☐ Humidity	☐ Damp
☐ Smog	☐ Sunlight	☐ A/C	☐ Change in temp.	☐ Rain.
Other Nasal Triggers:				

Eye History

☐ Tearing	☐ Burning	☐ Itching	☐ Pain	☐ Redness
☐ Puffiness	☐ Infection	☐ Discharge	☐ Blurry	☐ Dryness
Other:				

Ear History

☐ Pressure	☐ Itchy	☐ Drainage	☐ Bleeding
☐ Hearing Loss	☐ Swelling	☐ Infections	☐ Tubes
Other:			

Tongue History

☐ Swollen	☐ Sore	☐ Itching	☐ Coated	☐ Trouble Tasting
Other:				

Mouth/Throat History

☐ Itchy	☐ Recurrent Tonsillitis	☐ Morning Sore Throat	☐ Postnasal Drip
☐ Trouble Swallowing	☐ Mouth Breathing/Bad Breath	☐ Frequent Throat Clearing	☐ Change in Voice
☐ Heartburn	☐ Acid Reflux	☐ Vomit Burps	☐ Pain
Other:			

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Skin History (Check all that are bothersome when contacted)

☐ Wool	☐ Silk	☐ Sweater	☐ Shoes	☐ Dry Cleaning
☐ Starched	☐ Unwashed	☐ Cut Grass	☐ Flowers	☐ Plants
☐ Hay	☐ Christmas Tree	☐ Plastic	☐ Rugs	☐ Fiberglass
☐ Rubber	☐ Dust	☐ Feather Pillows	☐ Furs	☐ Jewelry
Other:				

What activities cause a rash or skin irritation?

☐ **Running**	☐ **Jumping**	☐ **Swimming**	☐ **Sports**

History of:

☐ Eczema	☐ Rashes	☐ Boils	☐ Infections	☐ Poison Ivy

Eczema Rash Reaction if applicable

List of foods:			
☐ Heat/Cold	☐ Pressure	☐ Scratching	☐ Sunlight
☐ Exercise	☐ Grass	☐ Tight Clothing	☐ Other

Chest/Lung History

☐ Shortness of Breath	☐ Wheezing	☐ Tightness
☐ Childhood Asthma	☐ Frequent Bronchitis	☐ Cough
☐ Chest Pain	☐ Difficulty getting air in	☐ Gradual worsening of symptoms
☐ Sudden worsening of symptoms	☐ Voice change with shortness of breath	☐ Blockage of air flow in chest or lungs
Do you use a rescue inhaler?	☐ Yes	☐ No
Does drinking water help?	☐ Yes	☐ No
Do you cough when laughing?	☐ Yes	☐ No
Do you prefer an Inhaler or Nebulizer?	☐ Inhaler	☐ Nebulizer
Do you use a spacer with your inhaler?	☐ Yes	☐ No
Do you use a mask with spacer or inhaler?	☐ Yes	☐ No
Do you check peak flow?	☐ Yes	☐ No
Do you have an Asthma Action plan?	☐ Yes	☐ No
Any ER visits due to respiratory problems?	☐ Yes	☐ No

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Patient Medical History

Please list all surgeries and date of surgery (mm/yy):
Please list any hospital stay not related to surgeries:

Family Medical History

Father:
Mother:
Sister:
Brother:
Sons:
Daughters:
Other diseases that run in your family:

Social History

Any Smoke Exposure?	☐ **Yes**	☐ **No**	**How Long?**
Do you Smoke / Vape (e-cigarettes)?	☐ **Yes**	☐ **No**	**Packs a Day?**
Have you ever Smoked?	☐ **Yes**	☐ **No**	**How Long?**
Do you drink Alcohol?	☐ **Yes**	☐ **No**	**How often?**
Do you use recreational Drugs?	☐ **Yes**	☐ **No**	**How often?**

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Environmental History

What type of home do you live in?				
☐ House	☐ Apartment	☐ Farm	☐ Manufactured	☐ Other
What type of heating?				
☐ Oil/Gas	☐ Electric	☐ Coal	☐ Gas Fireplace	☐ Wood Fireplace
Type of A/C				
☐ Central	☐ Window Unit	☐ Fan		
Do you live near a Farm?	☐ Yes	☐ No		
Do you use a humidifier?	☐ Yes	☐ No		
Do you use a HEPA filter?	☐ Yes	☐ No		
Any of the following in the house?				
☐ Book Shelf	☐ Ceiling Fans	☐ Stuffed Animals		
Any history of water leaks in your home?	☐ Yes	☐ No		

What type of flooring in the home?

☐ Carpet	☐ Wood	☐ Laminate	☐ Tile	☐ Other
Do you have dust mite covers on pillows & mattress?	☐ Yes	☐ No		
Do you have pets?	☐ Yes	☐ No		
How may pets if applicable?	_____Dogs	_____Cats		
Do you use aerosolized essential oils like peppermint/Lavender? if Yes, please list.				
How long have you lived in Oklahoma? List any other State you have lived in.				

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Sleep Questionnaire

This short self-evaluation questionnaire will assist your physician in the assessment of your risk for Obstructive Sleep Apnea (OSA). OSA is a sleep disorder which is diagnosed by pauses in normal patterns of breathing while you are asleep. OSA has been strongly linked to numerous medical conditions to include heart disease, diabetes, lung disease, vascular disorders, psychiatric conditions and can markedly increase surgical risks in certain populations. If your screening questionnaire suggests you may be at risk for a sleep disorder, your physician may discuss options with you to further evaluate your risk profile.

Please answer all of the following questions by selecting	**"YES"**	**or "NO"**
S (snoring) Have you ever been told you snore loudly?	☐	☐
T (tired) Are you often "tired" or sleepy during the day?	☐	☐
O (obstruction) Have you ever awakened suddenly from sleep gasping for air? Or has anyone witnessed you stop breathing while you are asleep?	☐	☐
P (pressure) Have you ever been diagnosed with high blood pressure or are you taking medication for high blood pressure?	☐	☐
B (BMI) Is your body mass index greater than 30? Weight____Height____(**If you are unsure of your BMI, simply provide your height and weight so your healthcare provider can calculate.**)	☐	☐
A (age) Are you 50 years old or older?	☐	☐
N (neck) Are you a male with a neck circumference larger than 17 inches, or female with a neck circumference larger than 16 inches?	☐	☐
G (Gender) Are you a male?	☐	☐

Number of "Yes" responses:_____/ (8 possible)

(High Probability of Obstructive sleep apnea diagnosis with 3 or more "YES" responses)

Thank you for completing this questionnaire regarding your overall sleep quality. Your physician may discuss options for further evaluation of your sleep if your profile suggests you may be at risk for a sleep disorder.

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Headache Questionnaire ☐ Does not apply to me

Do you know what might be causing your headache?		
☐ Sinus Pressure	☐ HTN	☐ Whiplash
☐ Diabetes	☐ Eye Strain	☐ Other
Has this type occurred before?	☐ Yes	☐ No
Is headache pain unbearable?	☐ Yes	☐ No
Does your neck, shoulders, or head junction feel tight during headache?	☐ Yes	☐ No
Is your headache pain dull and stead like constant pressure?	☐ Yes	☐ No
Does your headache feel like a tight band around your head?	☐ Yes	☐ No
Do you usually have more than one headache a week?	☐ Yes	☐ No
Do your headaches occur during the day?	☐ Yes	☐ No
Does any blood relative have similar headaches?	☐ Yes	☐ No
Does exertion affect your headache?	☐ Yes	☐ No
Does nausea or vomiting occur before or during your headache?	☐ Yes	☐ No
Do you have vision change with headaches?	☐ Yes	☐ No
Does your headache usually start on one side of your head?	☐ Yes	☐ No
Does your headache throb, pulsate, or feel like its pounding?	☐ Yes	☐ No
Does your headache occur during the night or upon awakening?	☐ Yes	☐ No
Do your headaches occur during weekends and holidays?	☐ Yes	☐ No
Is your headache associated with your menstrual cycle?	☐ Yes	☐ No
Do you have watering of the eye on the affected side?	☐ Yes	☐ No
Does alcohol cause or aggravate your headache?	☐ Yes	☐ No
Do any foods cause or worsen your headache?	☐ Yes	☐ No
Do you have any hearing problems with headache?	☐ Yes	☐ No
Do you have any facial pain, aching jaw, stuffiness or congested sinuses along with headache?	☐ Yes	☐ No
Has it been over 18 months since your last dentist appt.?	☐ Yes	☐ No
Have you had any test for headaches?	☐ Yes	☐ No

Please list any previous headache medication: **(Rx and OTC)**

Have you had any of the following problems :			
☐ Paralysis	☐ Muscle Weakness	☐ Swallowing	☐ Speech

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Hives Questionnaire ☐ Does not apply to me

Date of onset hives?	**Date:**		
Frequency of attacks? ☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly
Time of day when they happen? ☐ Morning	☐ Daytime	☐ Evenings	☐ After meals
Seasonal: ☐ Winter	☐ Aug-Sept	☐ Spring	☐ Summer
Physical: ☐ Heat	☐ Exercise	☐ Sunlight	☐ Rainy
☐ Damp	☐ Bathing	☐ Pressure	☐ Prolonged Sitting
☐ Vibration	☐ Rubbing	☐ Scratching	☐ Friction
☐ Clothing	☐ Other		
Contact: ☐ Animals	☐ Soaps	☐ Detergent	☐ Other
Hormonal: ☐ Stress	☐ Menstrual	☐ Pregnancy	☐ Other
Occupational: ☐ Indoors	☐ Outdoors	☐ Work	☐ Home
☐ Anywhere	☐ Weekends	☐ Vacations	☐ Housework
☐ Other			
Foods: ☐ Beer	☐ Bread	☐ Cake	☐ Cheese
☐ Cider	☐ Coffee	☐ Eggs	☐ Grapes
☐ Ham			
☐ Pork	☐ Ketchup	☐ Milk	☐ Mints
☐ Nuts			
☐ Pickles	☐ Seafood	☐ Strawberries	☐ Tomatoes
☐ Wine			
☐ Vinegar	☐ Sausage	☐ Kiwi	☐ Cucumber
☐ Other			

Treatments Tried for Clearing Hives: Rate medications 0=none,1=Slight,2=Moderate, 3=Clear		
☐ Antihistamine	☐ Zyrtec/Cetitizine	☐ Benadryl
☐ Atarax	☐ Hydroxyzine	☐ Singulair
☐ Steroids	☐ Prednisone	☐ Solumedrol
☐ Epinephrine	☐ Montelukast	☐ Other
Diet Elimination?	☐ Yes	☐ No
What foods?		
Antibiotic Elimination?	☐ Yes	☐ No
What Antibiotics?		
Other Eliminations?		

OKLAHOMA INSTITUTE of ALLERGY ASTHMA & IMMUNOLOGY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Oklahoma Institute of Allergy & Asthma *is committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. This notice describes your rights and our legal duties regarding your Protected Health Information ("PHI"). "Protected Health Information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic date. In this notice, we call that protected information, "medical information".*

HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION

Treatment. We will use your medical information to treat you. For example, we may disclose your medical information to other doctors, nurses, technicians, medical students, or other members of our staff who are involved in taking care of you or to other care professionals for additional treatment or follow up care such as home health services. We also may disclose your medical information to people outside our medical practice who may be involved in your care such as your family members.

Payment. We may use and disclose your medical information to receive payment for our services from you, an insurance company or a third party. For example, we may need to give your health plan information about a procedure we perform at our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose your medical information to operate this medical practice. For example, we may use this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also share your medical information with our business associates, such as a billing service, that perform administrative services for us. We have a written contract with each business associate that contains terms requiring them to protect the confidentiality of your medical information.

Appointment Reminders. We may use and disclose your medical information to remind you about appointments.

Sign-in Sheet. We may use and disclose your medical information by having you sign in when you arrive at the clinic.

Notification and Communication with Family. We may disclose your medical information to notify or assist a family member, or another person who is involved in your care unless you ask us not to. In the event of a disaster, we may disclose information to a relief organization, such as the Red Cross, so that they may

Coordinate these notification efforts. We may also disclose information to someone who pays for your care. If you are unable to agree or object to these disclosures, our health professionals will use their best judgment in communicating with your family and others.

With Your Authorization. We may disclose your medical information for purposes not described in this notice or otherwise permitted by law only with your written authorization. You may revoke an authorization at any time, in writing, but only as to future uses or disclosures, and only where we have not already acted in reliance on your authorization. Revocations should be delivered to the Clinic Privacy Officer.

Required by Law. We may use and disclose your medical information when required to do so by law, but only to the extent and under the circumstances provided in that law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Public Health and Safety. Your medical information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability; to report birth defects or infant eye infections; to report cancer diagnoses and tumors; to report child abuse or neglect or child born with alcohol or other substances in its system; to report reactions to medications or problems with products; to notify you of recalls of products you may be using; to notify the Oklahoma State Department of Health that a person may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition such as HIV, syphilis, or other sexually transmitted diseases; or to notify the appropriate governmental authority if we believe a patient has been the victim of abuse, neglect, or domestic violence, if the victim agrees to our reporting or if we are required to do so by law. Your medical information may be disclosed to appropriate persons in order to prevent or lessen a serious and imminent threat to you or to the health and safety of a particular person or the general public.

Specializing Government Functions. We may disclose your medical information for military or national security purposes, national intelligence, protection of the President, or to correctional institutions or law enforcement officers that have you in their lawful custody.

Military. If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities necessary for the government to monitor the health care system, government programs, and compliance with applicable laws. These oversight activities include, for example, audits, investigations, inspections, medical device reporting and licensure.

Coroners/Funeral Directors. We may disclose your medical information to coroners in connection with their investigations of death or to funeral directors to enable them to carry out their lawful duties.

Organ or Tissue Donation. We may disclose your medical information to organizations involved in procuring, banking or transplanting organs, eyes and tissues, as necessary to facilitate organ, eye or tissue donation or transplantation.

Workers' Compensation. Your medical information may be used or disclosed as required by law related to workers' compensation.

Law Enforcement. Your medical information may be disclosed to law enforcement authorities to identify or locate suspects, fugitives or witnesses, or victims of crime (with your consent in some circumstances) and to report possible deaths caused by criminal activities or to report crimes on the premises.

Research. We may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information and has approved the research.

By Oklahoma law we are required to notify you that your medical information used or disclosed as described in this Notice of Privacy Practices may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

YOUR MEDICAL INFORMATION RIGHTS

You have the right:

-To receive a paper copy of this *Notice of Privacy Practices*.

-To request restrictions on certain uses and disclosures of your medical information by written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision. If we agree to a restriction, we may disregard it if the information is needed to provide you emergency treatment.

-To request that you receive medical information in a specific way or at a specific location. For example, you may ask that we send information to your work address. We will comply with all reasonable requests submitted.

-To review and obtain an electronic or paper copy of your medical information, with limited exceptions defined by law.

-To receive an accounting of disclosures made of your medical information by this medical practice unless the disclosures were for purposes of treatment, payment, health care operations, certain government functions, or pursuant to your written authorization.

Contact:

If you would like to have a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact the Privacy Officer.

Changes to this Notice: We reserve the right to change or amend this *Notice of Privacy Practices* at any time in the future. After an amendment is made, the revised *Notice of Privacy Practices* will apply to all protected health information that we maintain. A copy of any revised *Notice of Privacy Practices* will be made available to you at each appointment.