



Allergy, Asthma & Immunology of the Rockies, P.C.
 Robert McDermott, M.D. Diplomate The American Board of Allergy and Immunology
 Regan Pyle, D.O. Diplomate The American Board of Allergy and Immunology

P. 970.947.0600 | F. 970.947.0601 | www.allergyoftherockies.com
 Main Office: 120 Midland Ave., Suite 230, Glenwood Springs, CO 81601
 350 Market St., Suite 200, Basalt, CO 81621 | 50 Buck Creek Rd., Suite 105, Avon, CO 81620
 377 Sylvan Lake Rd., Suite 140, Eagle, CO 81631 | 400 West Main St., Suite 100, Aspen, CO 81610

Patient Registration Form

Patient Name (Last, First, Middle Initial)	Patient Date of Birth	Patient SSN
Patient Mailing Address	City/State/Zip Code	Marital Status
Preferred telephone number	Secondary telephone number	Email Address (for appointment reminders)
Primary Care Physician's Name*	Practice's Name	PCP's Phone Number
Primary Care Physician's Address	City/State	Zip Code
Specialist Physician's Name*	Practice's Name	Specialist's Phone Number
Specialist's Address	City/State	Zip Code
How did you hear about us: <input type="checkbox"/> Primary Care Physician Referral <input type="checkbox"/> Specialist <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet <input type="checkbox"/> Advertisement <input type="checkbox"/> Family <input type="checkbox"/> Insurance <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Other		
* I authorize AAIR, P.C. to send a written report to my above Doctors: <input type="checkbox"/> Yes <input type="checkbox"/> NO		
* I authorize AAIR, P.C. to contact me via E-mail and or Text message <input type="checkbox"/> Yes <input type="checkbox"/> NO		

*For the below information, *if the patient is a child*, please fill out the parent/legal guardian's information. *
 *If the patient is an adult, please fill out the following employment information *for the patient and spouse* if applicable.*

Name	DOB	SSN	Name	DOB	SSN
Mailing Address			Mailing Address		
City/State/Zip		Home Phone #	City/State/Zip		Home Phone #
Employer Name		Work Phone #	Employer Name		Work Phone #
Employer Address			Employer Address		
City/State/Zip			City/State/Zip		

Emergency Contact Name
Relationship
Home Phone Number

Primary Insurance		Secondary Insurance	
Insurance Name		Insurance Name	
Policy/Subscriber Number	Group Number	Policy/Subscriber Number	Group Number
Subscriber Name/DOB/SSN		Subscriber Name/DOB/SSN	

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Robert McDermott, MD when he accepts assignment.

Patient Signature/Legal Guardian: _____ Date: _____

Witness Signature: _____ Date: _____



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DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing Allergy, Asthma & Immunology of the Rockies, P.C. of your wish to designate the named person as your personal representative. Your personal representative will be treated as the subject of your protected health information and shall have the right to act on behalf in making health care decisions.

You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to the front office receptionist.

DESIGNATION SECTION

I _____ (*print*) hereby nominate _____ (*print*) to act as my personal representative with respect to decision involving the use and/or disclosure of health information that pertains to me.

This person is to be afforded all privileges that would be afforded to me with respect to my health information when acting as my personal representative.

I understand that I may revoke this designation at any time by signing the revocation section of this form and returning it to the front office. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Patient Signature

Date

REVOCAION SIGNATURE

I hereby revoke this designation of a personal representative.

Patient Signature

Date



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Private Policy HIPAA Acknowledgement

I, _____ (patient), acknowledge that I have received a copy of Allergy Asthma & Immunology of the Rockies, P.C. Notice Regarding Privacy of Personal Health Information.

Date

Patient/Guardian Signature

Relationship to patient if not patient



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Financial Policy

Welcome to Allergy, Asthma, & Immunology of the Rockies. It is important that all our Policies are fully understood by you to ensure you receive continuous, experienced and timely health care. Please read this policy and acknowledge your understanding and agreement with your signature. We invite you to ask questions and/or clarifications if you have any. Thank you.

I agree that:

AAIR, PC. will bill my insurance, provided all the necessary information is given to the clinic at the time of service. This includes a valid, current insurance card. If this is not available, I will be asked to pay all charges for the date’s visit before I leave the office. AAIR, PC will ask to see your insurance card at every visit to ensure that we have all the proper billing data and that the card is current.

If my insurance company does not submit payment within 30 days, I understand I will be responsible for any and all outstanding balances. I am aware that my insurance carrier, rather than my physician, may deny some services for the reason of “not medically necessary” or “non-covered services, therefore, I will become fully responsible for payment of these services.

If I have asked for an estimate of cost for my visit, this will be given as closely as possible. However, since AAIR, PC is not aware of the exact number of skin tests, level of care etc. that will be needed until the physician has seen the patient; this is considered only as an estimate and not an exact charge quote.

I assume all responsibility for the deductible costs of my insurance plan. These costs will be billed to me immediately by AAIR, PC when my insurance plan states that these are my costs and not theirs.

AAIR, PC will make all attempts to collect payment from the insurance carrier; however, I am ultimately responsible for all costs associated with my visit. Though insurance coverage may be carried, it is not a guarantee of payment. I understand that if my insurance company fails to pay AAIR, PC, any remaining balance will be my financial responsibility and will be paid in full upon receiving a statement of balance. I will pay this balance within 15 days or contact AAIR, PC to make financial arrangements. I agree to allow AAIR, PC to telephone me at any of my phone numbers given to AAIR, PC to discuss any issues regarding payment of my account. A late fee of \$20.00 will be assessed if my account is not paid in 45 days. All bills must be paid in full within 57 days or my account may be sent to an outside collection agency. Once this is done, I must deal directly with the collection agency and not AAIR, PC as it is out of their hands to do anything with my account. This agency will add the appropriate fees for collection if my account is sent there. At this time AAIR, PC will cease giving care to me and my dependents.

Signature of Patient (or Legal Guardian)

Date



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Cancellation of Appointments

Our goal at AAIR, PC is to provide high quality medical care in a timely manner. In order to do so, we have had to establish an appointment cancellation policy. This policy will enable us to better utilize available appointments for our patients in need of medical care.

A scheduled appointment means that time is reserved only for you. We ask that you call at least **48** hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient in need of timely medical care. Failure to give **48** hours notice prior to cancellation may result in a “No-show” appointment fee of \$25. This fee cannot be billed to your insurance company and will be your direct responsibility.

To cancel, please call 970-947-0600 and dial 0 to speak to the front desk. Before or after regular business hours, please leave a message with your name, appointment time, reason for canceling and a phone number for us to reach you to reschedule.

Thank you for your understanding in this matter.

Signature of Patient (or Legal Guardian)

Date



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Consent for Testing and Authorization of Treatment of a Minor (Patients under 18 years of age)

I do hereby give authorization and consent for the patient designated below to be evaluated and, when indicated, treated by Robert McDermott, MD and his staff without the presence of a parent or guardian. In addition, I give authorization and consent for treatment of any reactions that may occur as a result of testing without the presence of a parent or guardian.

Printed Name of Patient

Medical Record Number

Parent/Legal Guardian Signature

Date

Family Representative Signature

Date

Witness

Date



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PATIENT INTAKE QUESTIONNAIRE

PATIENT NAME _____ DATE OF BIRTH _____

WHAT BRINGS YOU IN TODAY? _____

WERE YOU REFERRED, AND IF SO BY WHOM? _____

HAVE YOU EVER BEEN EXPOSED TO TUBERCULOSIS OR HAD A POSITIVE TB SKIN TEST? **YES** **NO**

ALLERGIES: (IF NO, CIRCLE NO, AND MOVE ON TO NEXT SECTION) NO

- SNEEZING
- RUNNY NOSE
- NASAL CONGESTION BOTH SIDES? _____
- POST NASAL DRIP
- BLOODY NOSE
- SENSE OF SMELL IMPAIRED
- SENSE OF TASTE IMPAIRED
- EYES: ITCHY WATERY RED SWOLLEN EYELIDS IMPAIRED VISION COLORED DISCHARGE
- IMPAIRMENT OF WORK OR SCHOOL?
- TRIGGERS:
 - SEASONS: SPRINGSUMMER FALL WINTER YEAR ROUND
 - ANIMALS
 - WORKING OR PLAYING OUTDOORS
 - STRONG ODORS/PERFUMES
 - DUST EXPOSURE
 - TEMPERATURE CHANGES
 - ASPIRIN INGESTION
- HISTORY OF NASAL POLYPS
- HISTORY OF DEVIATED SEPTUM
- HISTORY OF SEPTAL PERFORATION
- HISTORY OF RECURRENT SINUS INFECTIONS?
 - IF YES HOW MANY PER YEAR? _____
 - RECENT COLORED NASAL DISCHARGE? _____ COLOR _____
 - FACIAL PAIN, HEADACHES? _____
 - HISTORY OF SINUS SURGERY? _____
 - SINUS CT? _____ WHEN/WHERE? _____
- NEED FOR ORAL STEROIDS? (Eg. ORAPRED, PREDNISONE TABLETS OR SYRUP, MEDROL, STEROID INJECTIONS) How many times in the last year _____
- NASAL OBSTRUCTION
- SNORING
- DISRUPTED OR UNRESTFUL SLEEP
- DAYTIME SLEEPINESS OR NAPS
- OCCASIONALLY STOP BREATHING WITH EXCESSIVE SNORING
- PREVIOUS MEDICATIONS:
 - NASAL STEROIDS EFFECTIVE/NOT EFFECTIVE
 - ANTIHISTAMINES EFFECTIVE/NOT EFFECTIVE
 - SINGULAIR EFFECTIVE/NOT EFFECTIVE

PATIENT NAME: _____

CHEST AND LOWER RESPIRATORY SYMPTOMS

- HISTORY OF ASTHMA AGE DIAGNOSED? _____
- WHEEZING
 - WHILE BREATHING OUT? IN? BOTH?
 - >2 TIMES PER WEEK AT REST DURING THE DAY
 - DAILY SYMPTOMS AT REST
 - NIGHTTIME SYMPTOMS >2 TIMES PER MONTH
 - EXERCISE INDUCED WHEEZE OR COUGH
- EPISODES OF TURNING BLUE
- HOSPITALIZED FOR ASTHMA: LOCATION? _____ WHEN? _____
- INTENSIVE CARE UNIT OR RESPIRATOR REQUIRED
- EMERGENCY DEPARTMENT FOR ASTHMA: LOCATION? _____ WHEN? _____
- FREQUENCY OF ALBUTEROL OR RESCUE INHALER USE? _____
- NEED FOR ORAL STEROIDS? (Eg. ORAPRED, PREDNISONE TABLETS OR SYRUP, MEDROL, STEROID INJECTIONS)
 - How many times in the last year _____
- MISSED SCHOOL OR WORK

- COUGH
 - BRINGS UP SPUTUM, AND IF SO, COLOR? _____
 - DRY NONPRODUCTIVE
 - DISRUPTS SLEEP OR WORSE AT NIGHT
 - BLOOD IN SPUTUM
 - HISTORY OF TB (TUBERCULOSIS) EXPOSURE
- ACID REFLUX SYMPTOMS

- TRIGGERS OF YOUR SYMPTOMS:
 - SEASONS: SPRING SUMMER FALL WINTER YEAR ROUND
 - ANIMALS
 - WORKING OR PLAYING OUTDOORS
 - STRONG ODORS/PERFUMES
 - DUST EXPOSURE
 - TEMPERATURE CHANGES
 - ASPIRIN INGESTION
 - EXERCISE
 - TOBACCO SMOKE EXPOSURE
- MEDICATIONS FOR ASTHMA?
 - ALBUTEROL/XOPENEX?
 - FREQUENCY OF USE _____

OTHER MEDICATIONS?:

PATIENT NAME: _____

PAST MEDICAL AND ALLERGIC HISTORY

MEDICAL PROBLEMS:

HOSPITALIZATIONS:

ER VISITS:

SURGERY:

FOOD REACTIONS:

LATEX:

INSECT STINGS:

IMMUNIZATIONS:

MEDICATIONS:

BETA BLOCKER OR ACE INHIBITOR FOR HIGH BLOOD PRESSURE? _____

DRUG ALLERGIES OR ADVERSE REACTIONS:

PATIENT NAME: _____

ENVIRONMENTAL AND SOCIAL:

HOME/APT (FLOOR) STYLE: LENGTH OF OCCUPANCY

HEAT (CENTRAL FORCED AIR / RADIATOR)

AIR CONDITIONING (CENTRAL / WINDOW UNITS) HUMIDIFIER (CENTRAL / SEPARATE UNITS)

BASEMENT (DAMP MUSTY SEEPAGE FLOODING)

BEDROOM BOX SPRING / MATTRESS COVERS (YES NO)

PILLOW: FEATHER NON FEATHER COMFORTER: FEATHER NON FEATHER

FLOORING:

LIVING AREA: _____

BEDROOM: _____

BASEMENT: _____

PETS: DOG (s) _____ CAT(s) _____ BIRD(s) _____ OTHER:

BEDROOM PETS: _____

PREV. PETS _____

SMOKERS: _____

OCCUPATION: _____

SMOKING: CURRENT? Yes/No Packs per day if yes? _____ Number of Years _____ PAST SMOKING HISTORY? _____

SECONDARY TOBACCO SMOKE EXPOSURE? _____

DRUG/ALCOHOL USE _____

HOBBIES: _____

FAMILY HISTORY:

PARENTS:

ASTHMA: _____

ALLERGIES: _____

OTHER: _____

SIBLINGS:

ASTHMA: _____

ALLERGIES: _____

OTHER: _____

OTHER:

HISTORY OF CYSTIC FIBROSIS OR OTHER LUNG DISORDERS? _____

PATIENT NAME: _____

REVIEW OF SYSTEMS

General/Constitutional yes no

- Weight loss or gain, ____lbs Fever Night sweats decreased energy

Skin: yes no

- Rash itching dryness changes in hair growth or loss nail changes
 Unusual appearing or large moles

Eyes: yes no as previously discussed

- Cataracts Glaucoma Loss of vision blurred vision Eye pain

Ears/Nose/Mouth/Throat yes no as previously discussed

- Headaches (location, time of onset, duration, precipitating factors), vertigo, lightheadedness, injury
Nose bleeding
Dental difficulties, gum bleeding, dentures
Neck stiffness, pain, tenderness, masses in thyroid or other areas
Difficulty swallowing painful swallowing

Cardiovascular yes no

- Chest pain Heart palpitations Left arm pain, numbness Murmur difficulty
breathing while lying flat lower extremity swelling

Respiratory yes no as previously discussed

- Shortness of breath, wheezing, stridor, cough respiratory infections, tuberculosis (or exposure to tuberculosis)

Gastrointestinal yes no

- Abdominal pain heartburn nausea vomiting constipation diarrhea
abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling)

Genito-urinary yes no

- Increased frequency urgency blood in urine prostate problems
kidney problems

Musculo-skeletal yes no

- Pain swelling in joints hands or legs redness or heat of muscles or joints
limitation of motion muscular weakness muscle cramps

Neurologic/Psychiatric yes no

- Convulsions or seizures Depression Anxiety Hyperactivity ADHD
Dizziness or passing out

Endocrine yes no

- Thyroid disorder heat intolerance cold intolerance excessive thirst/hunger

Blood/Lymphatic yes no

- Swollen lymph nodes or "glands" Easily bruise Bloody gums or bleed easily history of
lymphoma
HIV testing positive negative Blood transfusion

Are you pregnant or planning pregnancy? yes no