Diplomate American Board of
Allergy and Clinical Immunology

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Gregory W. Bensch, M.D.
Michael C. Balduzzi, M D.
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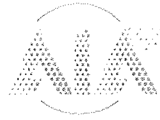

ALLERGY IMMUNOLOGY &ASTHMA MEDICAL GROUP

4628 Georgetown Place
Stockton, California 95207

Telephone: 209.951.5353
Fax: 209.951.5369

Date ________________ *Doctor: B GB MB JB Acct#* ______________ *M*____ *F*_____ *E-Script* ___

PATIENT INFORMATION

PATIENT'S LAST NAME ________________________ FIRST NAME ______________________ MI____

DATE OF BIRTH _____/_______/________ AGE_______ SOCIAL SECURITY ______-_________-__________

MAILING ADDRESS ____________________________ CITY _______________ STATE _____ ZIP_____

HOME TELEPHONE (   ) ________________________ CELL (   ) __________ WORK (   )__________

CELL PHONE CARRIER ________________________ EMAIL ADDRESS ________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ☐ PHYSICIAN ☐ FRIEND ☐ SELF

FAMILY DOCTOR/FRIEND NAME: ___________________________ CITY LOCATION _______________

IF THE PATIENT IS A MINOR OR STUDENT: PARENT/GUARDIAN- RESPONSIBLE PARTY:

PARENT NAME ____________________________ DOB: ____________ RELATIONSHIP _______________

ADDRESS IF DIFFERENT THAN ABOVE _______________________ CITY __________, CA_____ ZIP_____

INSURANCE INFORMATION – SPOUSE, PARENT, GUARDIAN, OR RESPONSIBLE PARTY

PRIMARY INSURANCE __________________________ MEDICAL GROUP/HMO ____________________

MEMBER ID # __________________________________ GROUP #____________________________

INSUREDS NAME________________________________ RELATIONSHIP TO PATIENT_______________

INSUREDS DOB________________ SS# _____-____-______ EMPLOYER________________________

EMPLOYERS ADDRESS ___________________________ CITY______________ STATE______ ZIP_____

SECONDARY INSURANCE ________________________ MEDICAL GROUP/HMO____________________
MEMBER ID # __________________________________ GROUP #____________________________

INSUREDS NAME________________________________ RELATIONSHIP TO PATIENT_______________

INSUREDS DOB________________ SS# _____-____-______ EMPLOYER________________________

EMPLOYERS ADDRESS ___________________________ CITY______________ STATE______ ZIP_____

PREFERRED PHARMACY ________________________ **LOCATION** _________________________

I authorize and release any medical information necessary to process any medical services rendered. I authorize payment of medical benefits to the undersigned physicians and agree that I am responsible for any balance of my account for any professional services rendered.

Signature ____ **Date**__________________________

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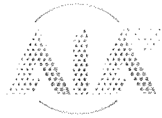

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PATIENT MEDICAL & HISTORY FORM – PAGE 1

PATIENT NAME ______________________________ **DOB** ___________________________ **DATE** ____________

Please describe how we can help: ____

Does the patient have any of the following conditions, symptoms or diagnoses?

Hay fever/Allergy Symptoms: Nasal, Eye, etc.	
Asthma Symptoms: Cough, wheeze	
Skin Problems: Itch, rash, hives, eczema	
Other Allergic Concerns:	

Has the patient ever been tested for allergies in the past? NO YES (If yes, blood test or skin test)

Known Allergies to Medication, Food, Insects or Materials (metals, soaps, etc.):

____

PLEASE LIST ALL ASTHMA INHALERS AND NASAL SPRAYS

NAME OF ASTHMA INHALER	DOSE/HOW MANY PUFFS & TIMES PER DAY?	NASAL SPRAYS/MEDICATION	HOW MANY TIMES PER DAY & HOW MANY SPRAYS

PLEASE LIST ALL OTHER MEDICATIONS YOU ARE CURRENTLY TAKING

NAME OF MEDICATION	DOSE/HOW OFTEN	NAME OF MEDICATION	DOSE HOW OFTEN

LIST MEDICAL CONDITIONS/DIAGNOSES	LIST PAST SURGERIES/PROCEDURES

PATIENT'S FAMILY MEDICAL HISTORY – PAGE 2

	MEDICAL	ASTHMA	ECZEMA	FOOD/MEDS	COPD
MOTHER					
FATHER					
SIBLINGS					
CHILDREN					

Environmental and Social History

Current or past smoker: **YES** **NO** Packs per day ____________________

If quit, what year: ______________ Total years of smoking ______________

Second Hand smoke: **YES** **NO** Current smokers at home? **YES (in or out)** **NO**

Is the Patient Currently: **Student** **Employed** **Unemployed** **Retired** **Disabled**

Most recent Job/Employment or grade: ____

(If child) does the child attend DAYCARE: YES Days/week ____________ NO

Physical Activity: __________________________________ **Hobbies:** _________________________________

Home environment: How long have you lived in your current home? ______________________________

Flooring: Carpet Wood Vinyl Tile

Heating: CentralWall Fireplace/Wood burning stove

Cooling: CentralWall Water cooler House Fan Floor/Ceiling fans

Does your heating and/or cooling unit use filters? YES NO

Approximately how often are they changed/cleaned? _________________________

Are there pets at home?	**How many?**	**Indoors**	**Bedroom**	**Outdoors**
Cats				
Dogs				
Small Mammals (ex. Mouse)				
Livestock/farm				
Birds				

Does your home have visible mold damage or required mold repair in the last year: YES NO

Do you sleep with windows open in your bedroom: YES NO

Do you use feather or down bedding/pillows: YES NO

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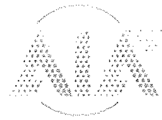

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WE ARE REQUIRED TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION (HIPAA)

Please advise (if any) who we may disclose your information to: Name/Relationship ______________________

EMERGENCY INFORMATION

In the event of an emergency who may we contact?

Emergency Contact Name______________________Relationship______________

Phone # (   ) ______________________Alternate # (___) ______________

Address ______________________City ____________ST_____ZIP________

PLEASE READ THE INFORMATION BELOW TO UNDERSTAND OUR OFFICE POLICIES

INSURANCE INFORMATION

- ✓ We understand that medical expenses can be a concern. If you are not familiar with your insurance benefits, please contact your insurance company so you are aware of your out of pocket patient responsibility; such as, co-payment, co-insurance, and/or deductibles prior to any and all services with AIAMG.
- ✓ Please bring your current insurance card(s) to each visit. This is important so we can bill your insurance company appropriately.
- ✓ If your insurance changes, it is your responsibility to notify the office receptionist immediately. Some insurances require prior authorization or a referral to continue treatment. Therefore, AIAMG will not render services, or continue treatment, until the proper authorization or referral is received.
- ✓ If AIAMG does not have a current authorization or referral for your visit, you will be asked to reschedule your visit. We will notify the patient in advance if the authorization/referral is not available.
- ✓ Diagnostic and laboratory services: Your health insurance policy determines which laboratories are contracted. AIAMG makes every effort to send the patient to an outside contracted facility; however, if the imagining center or laboratory is not contracted with your insurance provider, it may result in additional costs that you will be responsible for. Therefore, confirm with your insurance or the facility.

I understand the above information. Patient/Guardian initials __________

CO-PAYMENTS, DEDUCTABLES, AND OUT OF POCKET PATIENT RESPONSIBILITY

- ✓ Co-payments are paid at the time of service. AIAMG accepts cash, credit card, personal/bank checks, and PayPal.
- ✓ The patient/guardian is responsible for deductibles, co-insurance responsibilities, or any services rendered that are not covered by your insurance. AIAMG encourages patient balances to be paid in full; however, patients who have an outstanding balance will receive a monthly statement. If payment is not made within 60-90 days, our collection process will begin.

I understand the above information. Patient/Guardian initials __________

APPOINTMENTS

- ✓ AIAMG offers appointments in person, and Telehealth appointments to help accommodate your needs. Telehealth appointments can not be offered if the patient is acutely ill, or requires a physical exam to diagnose the patient correctly.
- ✓ AIAMG understands a patient may have to reschedule or cancel his/her appointment; however, we do require a 24-hour cancellation notice. If the patient does not cancel or reschedule their appointment, AIAMG may charge up to a $25 non-cancellation fee.
- ✓ If multiple appointments are rescheduled, canceled, or no show; AIAMG has the right to discontinue services with the patient. AIAMG will then refer you back to your primary care physician, or your counties Medical Society for another allergy & immunology physician.
- ✓ Please arrive to your scheduled appointment on time. If you are 15 minutes late, AIAMG will have to reschedule your appointment.

I understand the above information. Patient/Guardian initials ________

PROFESSIONAL CONDUCT

Adhering to the highest standards of professional conduct, employees are expected to demonstrate integrity, respect, and accountability in all their interactions and decision-making processes. In return, our office will not tolerate any offensive behavior, or profane language from our patients. Unprofessional misconduct could result in being dismissed as a patient. If for any reason you feel you are not treated fairly, you may ask for an immediate supervisor.

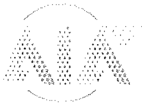
I understand the above information. Patient/Guardian initials ________

Allergy Skin Testing and Medical Procedures

Allergy testing and medical procedures require every patient to stay off medications that have active ingredients that will block accurate allergy testing. This includes over the counter medications. Most medications require the patient to discontinue the medication 7 days prior to your visit. Other medications require you to discontinue for 1-3 days. A list of medications and the time frame to stay off of the medication is provided on the next page.

- ➢ If your medication is not listed on the medication list – do not discontinue your medication.
- ➢ If you are not able to stay off of the medication, do not reschedule your appointment. Your physician will give you instructions and create a treatment plan for you to return for allergy testing.
- ➢ If you did not stop your medications as indicated, allergy skin testing can not be performed during your initial visit. However, you will still consult with the doctor and have a physical exam.

I understand the above information. Patient/Guardian Initials ________



ALLERGY IMMUNOLOGY & ASTHMA
MEDICAL GROUP

HIPAA – NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how medical information about the patient may be used & disclosed. For your convenience, this is a brief summary of the HIPAA guidelines. If you would like a copy of our full HIPAA policy, you may request a full copy.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, if requested, we will send your medical records to your insurance company for payment.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities. Such as, medical students in training, insurance audits and reviews. In addition, we may use a sign-in-sheet at the registration desk and call you by name in the waiting room. We may use or disclose your PHI, as necessary, to contact you by phone to remind you of scheduled appointments, or ask questions regarding your insurance. We may use or disclose your PHI in the following situations: The situations include: as Required by Law, Public Health issues such as Communicable Diseases, Health Oversight, Abuse or Neglect, FDA, Law, Coroners, Workman's Comp, etc.

Your Rights: You have the right to request a restriction of your PHI: This means you may ask our office not to use or disclose any part of your PHI for the purposes of the above treatment. Your request must state the specific restriction requested and whom you want the restriction to apply. Our office will notify you if the physician cannot grant your request, or feels it is in your best interest to permit use and disclosure of your PHI. You then have the right to use another Healthcare professional. You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. This must be requested in writing.

Grievances: You may report to us or to the Secretary of Health and Human Services if you believe your privacy right have been violated by our office. You may file a grievance with our HIPAA Compliance Officer in person or via phone at (209) 951-5353.

Signature below in only acknowledgement that your have reviewed the Notice of our Privacy Practices:

Print Patient Name: ________________________ **Signature:** ______________________________ **Date:** ________

Allergy Immunology & Asthma Medical Group, Inc.

The medications listed below must be stopped prior to skin testing. Please review this list and locate any medications you are currently taking and stop them for the period of time indicated. Please be aware many over the counter medications have antihistamine and would interfere with the skin testing.

If you have any questions about a medication or if you feel you cannot safely stop the medication please call the office at (209) 951-5353.

***** If you cannot withhold your medication prior to your visit *****

DO NOT RESCHEDULE YOUR APPOINTMENT

Stop 24 hours prior to testing	Stop 72 hours prior to testing	Stop 7 days prior to testing
<u>Antacids</u> -Axid (nizatidine) -Tagamet (cimetidine) -Pepcid (famotidine) -Zantac (ranitidine) <u>Nasal Sprays</u> Nasal Sprays are OK to use EXCEPT Astelin, Azelastine, Patanase, Astepro or Dymista Stop Astelin, Patanase, Astepro , Dymista at least 48 hours prior to your visit <u>Asthma meds</u> OK to use prior to your visit <u>Eye Drops</u> Stop 72 hours prior to your visit Patanol, Pataday, Optivar, Naphcon A, Vasocon A, Elestat, Zaditor, Bepreve, Ophcon A, Alaway, Lastacaft, Pazeo, Visine A <u>Patch Testing</u> Stop oral steroids for 30 days prior to visit (i.e. prednisone/prednisolone, medrol)	<u>STOP</u> all Allergy, Cold, Cough or Sinus meds or any med that contain antihistamines -Actifed -Advil PM -Antivert -Bonine -Bromfed (brompheniramine bromax) -Benadryl (diphenhydramine) -Chlor Trimeton (chlorpheniramine) -Deconamine -Dramamine -Excedrin PM -Meclizine -Naldecon -Pannaz -PBZ -Periactin -Phenergan -Poly Histine, Poly Histine D -Promethazine -Rynatan -Semprex, Semprex D -Sudafed Allergy -Tavist, Tavist D -Trinalin -Triaminic -Tylenol Allergy -Tylenol PM -Tylenol Cold & Sinus -Unisom (doxylamine) *All COLD & NIGHTTIME meds	-Adapin -Advil Allergy -Ah-Chew -Alavert -Allegra -Allegra D -Allerhist -Allertan -Allerx -Amitriptyline -Anafranil -Asendin -Atarax -Atrohist -Aventyl -BC Cold -Bentyl -Benztropine -Biohist -Carbinoxamine -Cetirizine -Claritin -Clarinex (desloratadine) -Clarinex D -Clemastine -Clomipramine -Cogentin -Comtrex -Contac -Coricidin -Cyproheptadine -Dayquil -Desipramine -Dimetapp -Doxepin -Dramamine -Drixoral -Durahist -Durotan -Duravent -Dytan -Elavil -Etrafon -Extendryl -Fexofenadine -Hydroxyzine -Imipramine -Limbitrol -Lodrane -Loratadine -Ludiomil -Marezine -Mirtazapine -Norpramin -Nortriptyline -Nyquil -Pamelor -Pedicare -Pediatan -Poly Hist -Protriptyline -Remeron -Rescon -Risperidone -Risperdal -Robitussin Cough -Cold & Allergy -Rondec -Rutuss -Ryna -Ryneze -Seroquel (Quetiapine) -Sinequan -Singlet -Sominex -Surmontil -Tacaryl -Tandur -Tavist -Temaril -Theraflu -Tofranil -Triavil -Trimipramine -Vicks -Vivactil -Zonalon -Zyrtec (cetirizine) -Zyrtec D -Xyzal (Levocetirizine)