

The Allergy and Asthma Center, P.C.

David Mangold, PA-C
20 Four Mile Dr., Suite 2
Kalispell, MT 59901
(406) 300-4882

WELCOME!

We look forward to providing your care. Before your first appointment, please read and familiarize yourself with AAC's office policies below.

PAPERWORK

Please complete the enclosed registration and questionnaire. Please take the time to fill out these forms completely and accurately. **All paperwork must be completed PRIOR to your scheduled appointment time.** Please be aware that if your paperwork is not completed when you arrive for your appointment, you may be rescheduled. Please also bring your completed paperwork, insurance card, and any required copayment to your appointment, if applicable.

ALLERGY TESTING

If you are scheduled to have allergy testing completed at your appointment, **please review the medications list on the reverse of this letter and STOP medications,** as appropriate. If you have any concerns about discontinuing any of your medications, please contact our office immediately.

APPOINTMENT

Your appointment is scheduled for _____ at _____

in Kalispell with David Mangold, PA-C.

CANCELLATION POLICY

Should you need to cancel your appointment, we require 24 hours notice. We understand that emergencies do occur, but habitual same day cancellations will have a \$50.00 charge assessed to your account. Please honor your appointments as best you can to avoid being charged this fee.

We look forward to meeting with you soon!

Thank you,

The Allergy and Asthma Center Staff

Medications Patients Must Stop Using Before Initial Visit or Skin Testing

48 HOURS

- Tagamet (cimetidine)
- Zantac (ranitidine)
- Pepcid (famotidine)
- Axid (nizatidine)
- Benedryl (diphenhydramine)
- Tylenol PM
- Phenergan (promethazine)
- Motion sickness medications
- Topical steroid creams on testing sites (back and arms)

ONE WEEK

- Any over the counter antihistamine medications
- Allegra (fexofenadine)
- Zyrtec (cetirizine)
- Xyzal (levocetirizine)
- Claritin (loratadine)
- Clarinex (desloratadine)
- Alavert (loratadine)
- Atarax (hydroxyzine)
- Astelin / Astepro (azelastine) – nasal spray
- Patanase (olopatadine) – nasal spray
- Zatidor / Alaway (ketotifen) – eye drops
- Patanol / Pataday (olopatadine) – eye drops
- Optivar (azelastine) – eye drops
- Livostin (levocabastine) – eye drops
- Elestat (epinastine) – eye drops

TWO WEEKS

All of these are a specific class of antidepressant, any other antidepressants are okay
THESE MEDICATIONS SHOULD NOT BE STOPPED UNLESS YOU CONSULT WITH YOUR DOCTOR.

- Tofranil (imipramine)
- Anafranil (clomipramine)
- Aventyl, Pamelor (nortriptyline)
- Elavil, Endep (amitriptyline)
- Norpramin (desipramine)
- Sinequan (doxepin)
- Surmontil (trimipramine)
- Vivactil (protriptyline)
- Luvox (fluvoxamine)
- Remeron (mirtazapine)

If you are reluctant to stop your medication we can still see you, but it may require a second visit for testing.

**Allergy & Asthma Center, PC
Financial Policy**

We require full payment of **expected patient responsibility** at the time of service based on your insurance coverage. If you do not have health insurance, we expect payment on the date of service. We do offer adjusted rates for "Time of Service" payments that are available to all patients, regardless of insurance coverage. This reduces our billing costs and further allows us to keep our charges as low as possible.

Unless you choose to participate in the "Time of Service" plan, we will submit charges to your insurance carrier when complete information is received. If insurance payment is delayed over 60 days, you will be expected to pay the balance. We will make all efforts to resolve issues of non-payment from your carrier. Any payments received from your insurance carrier after you have paid on your balance will be refunded to you with 14 days of receipt of overpayment.

If applicable, we will bill secondary insurance. Carrying primary and secondary policies does not alleviate all patient responsibilities: deductibles, co-pays, and patient responsibilities still apply. After receipt of insurance payments, the amount that is remaining is due in full within 14 days. We recommended reviewing all explanation of benefits received from all insurance companies.

If arrangements for payment are needed, a payment plan agreement will be completed and signed with our office staff. A confidential meeting will allow for questions and explanations of our policies. You will receive copies of all conditions agreed upon.

An insurance card must be presented at each office visit. Failure to present a card at the time of service will cause full payment due on that date.

Required referrals are the patient's responsibility. Failure to obtain referral as indicted by your insurance coverage will result in the charge to be completely the patient's responsibility and will be due at the time of service.

I have read and understand all policies listed above. I understand that I am responsible for payment in full for all charges from this office regardless of insurance coverage. I agree that insurance payments can be sent directly to The Allergy & Asthma Center, PC.

printed patient name

signature of responsible party

date

02.10.2015/mjm

The Allergy and Asthma Center, PC
Patient Questionnaire

Patient Name _____ Birth Date _____

Referring Physician _____ Date Questionnaire Completed _____

CURRENT MEDICAL HISTORY

1. What are the primary medical complaints today:

In the past year these problems are _____ worse _____ unchanged _____ better

2. List current medications (include dose and frequency):

3. Do you have any medication allergies? _____

If yes, list medication(s) and reaction: _____

PAST MEDICAL HISTORY

1. Significant childhood illnesses: _____

2. Other Medical Problems: (Diabetes, Heart Disease, Kidney Disease, High Blood Pressure, Arthritis, Cancer, etc.)

3. Surgeries? _____ If yes, specify and give year: _____

4. Hospitalizations? _____ If yes, specify and give year: _____

5. *As an infant* did patient have: Colic _____ Eczema _____ Many formula changes _____

Constant runny nose _____ Breathing problems _____ Any adverse reactions to immunizations _____

6. Has patient ever had any of the following tests? Indicate year and place done:

Chest X-Ray? _____ Sweat Test? _____ Breathing Tests? _____

Sinus X-Rays or CT scan? _____ Cardiac tests (EKG, echo, stress test) _____

PERSONAL HISTORY

1. Is patient in school? _____ Grade? _____

2. Number of school or work days missed due to illness? _____

3. Has the patient ever smoked cigarettes? _____ Age patient began smoking cigarettes regularly? _____

How many packs a day did the patient smoke? _____ Does patient currently smoke? _____

How old was patient when they quit? _____

4. Does patient drink alcohol regularly? _____

5. Does patient use any illegal drugs? _____

6. What has been the usual occupation or job for the patient? _____

7. Has the patient ever worked in any dusty or hazardous job? _____

Specify which job, total years of work, and amount of exposure. _____

8. Has the patient ever been exposed to gas or chemical fumes at work? _____

9. Specify which job, total years of work, and amount of exposure. _____

10. List patient's hobbies? _____

FAMILY HISTORY

1. Mother: Age if living _____ Age at death _____ cause of death _____

Father: Age if living _____ Age at death _____ cause of death _____

2. Does patient have any children? _____ If yes, list ages and any medical problems _____

3. Does patient have any siblings? _____ If yes, list ages and any medical problems _____

4. Please identify if parents (F/M), brother (B), sister (S), children (CH), grandparents (GF/GM) have any of the conditions listed below:

Asthma _____	Chronic Bronchitis _____	Hayfever _____
Sinus Trouble _____	Skin Allergy _____	COPD _____
Hives (welts) _____	Cystic Fibrosis _____	Emphysema _____
Autoimmune Disease _____	Repeated Infections _____	High Blood Pressure _____
Heart Disease _____	Arthritis _____	Other _____

ALLERGY HISTORY

1. Check any of the following symptoms that patient had or now has.

Nose and Throat

Frequent Colds
 Chronic Congestion
 Chronic Nasal Discharge
 Chronic Sniffing
 Frequent Sneezing
 Frequent Rubbing/Itching
 Frequent Sore Throats
 Polyps
 Sinus Problems
 Headaches
 Post Nasal Drip
 Throat Clearing
 Snoring

Eyes

Constant Circles
 Redness
 Itching/Rubbing
 Swelling

Chest

Chronic Cough
 Shortness of Breath
 Wheezing
 Wheezing Attacks
 Tightness in Chest
 Exercise Intolerance
 Exercise Induced Wheezing
 Exercise Induced Cough
 Sputum or Phlegm
 Pneumonia
 Bronchitis
 Frequent Croup

Ears

Congestion
 Frequent Infections
 Fluid
 Ear Tubes
 Hearing Loss
 Speech Problems

Skin

Eczema
 Hives (welts)
 Dryness
 Frequent Rashes

Miscellaneous

Tires Easily
 Irritable
 Poor Weight Gain
 Weight Loss
 Fevers
 Chills
 Night Sweats
 Reaction to Insect Bites
 Reaction to Insect Stings
 Greasy, Fatty Stools
 Heartburn
 Mouth Breathing
 Hard to wake in morning

2. Has patient ever had allergy tests? _____ When? _____ Findings? _____
3. Has patient ever had allergy shots? _____ If yes, did they help? _____
4. Does patient have any problems eating certain foods? _____
 If yes, specify foods and describe symptoms: _____

5. Check any of the following medicines or types of medicines you have used to treat your problem (s):
- _____ Antihistamines (Allegra, Xyzal, Zyrtec, Claritin, Chlortrimeton, Benadryl, etc.)
- _____ Nasal Sprays (Afrin, Astelin, Astepro, Patanase, Nasonex, Flonase, fluticasone, Nasacort, Rhinocort, Veramyst, etc.)
- _____ Breathing Treatments or Nebulizers
- _____ Oral or Injectable Steroids (Prednisone, Medrol, Cortisone, Kenalog, etc)
- _____ Inhalers, specify _____
- _____ Creams (triamcinolone, cortisone, Protopic, Elidel, etc.) _____
- _____ Other Medications (Singulair, Xolair, theophylline, etc.) _____

ENVIRONMENTAL HISTORY

1. What type of dwelling does patient live in? House _____ Apartment _____ Trailer _____
2. How old is the dwelling? _____ How many years lived there? _____
3. Is there any free standing water nearby? _____
4. Check those things listed below that apply to your home:

_____ Dehumidifier	_____ Central Air Conditioning/heat	_____ Air Purifier
_____ Humidifier	_____ Pet (s), Specify _____	_____ Problems with Mice
_____ Visible mold or mildew	_____ Does anyone you live with smoke? (Even if they smoke outdoors)	
_____ Home on a dirt road	_____ Do you live on a ranch	_____ Woodstove

5. Check any of the following that are in the patient bedroom:

- | | | | |
|---|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Plastic mattress cover | <input type="checkbox"/> Plastic box spring cover | <input type="checkbox"/> Stuffed toys | <input type="checkbox"/> Curtains |
| <input type="checkbox"/> Carpeting | <input type="checkbox"/> Feather Pillow | <input type="checkbox"/> Pets Allowed | <input type="checkbox"/> Books |
| <input type="checkbox"/> Air Conditioning | <input type="checkbox"/> Air Vent | | |

Additional notes or concerns:



Kalispell Hotel Reviews [TripAdvisor.com/Hotels](https://www.tripadvisor.com/Hotels) Find Kalispell Hotel Deals Save Up To 25% Off On TripAdvisor.

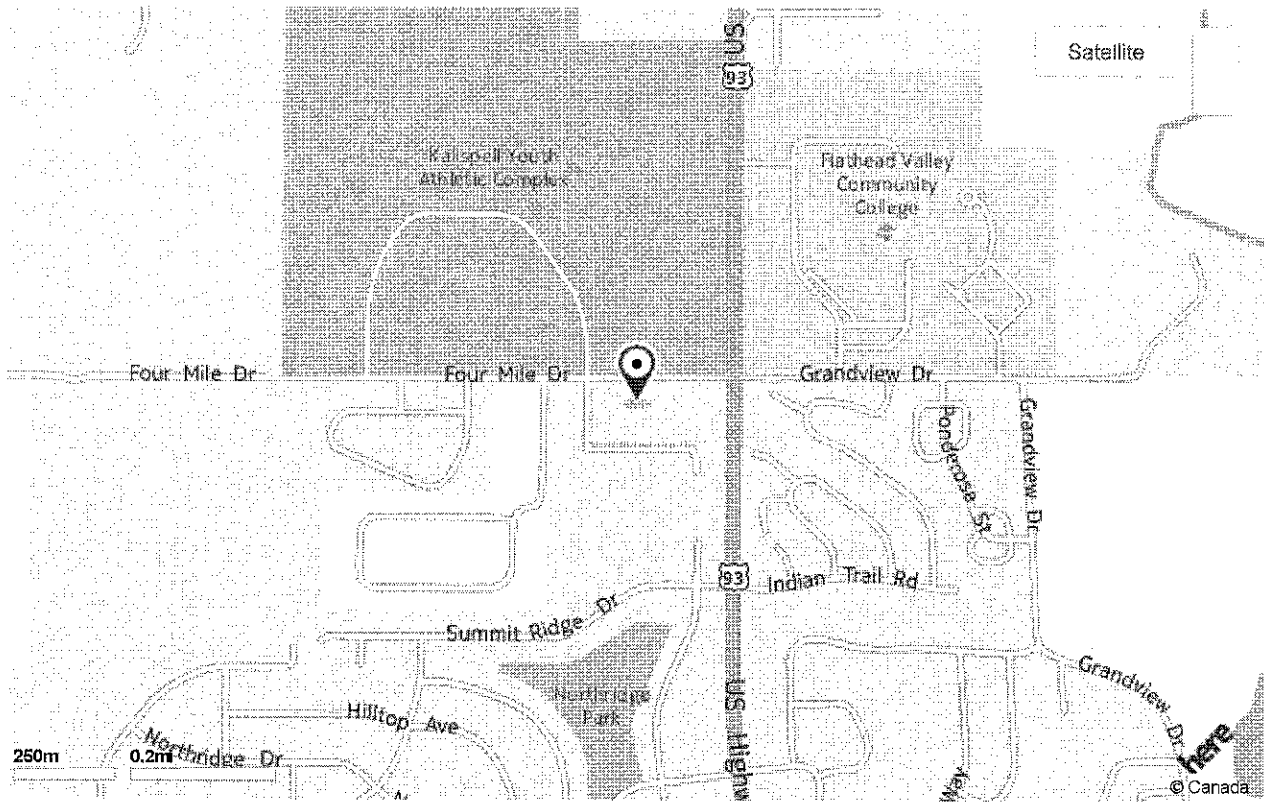
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YAHOO!
MAPS

20 Four Mile Dr, Kalispell, MT 59901-2631

Enter notes here

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When using any driving directions or map, it is a good idea to double check and make sure the road still exists, watch out for construction, and follow all traffic safety precautions. This is only to be used as an aid in planning