The Allergy and Asthma Center, P.C.

David Mangold, PA-C
Arlon Bennett, FNP-C
Ruth West, PA-C
900 N. Orange St., Ste. 207
Missoula, MT 59802
(406) 721-4540

David Mangold, PA-C
Arlon Bennett, FNP-C
20 Four Mile Dr., Ste. 2
Kalispell, MT 59901
(406) 721-4540 – Scheduling Office

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 Missoula with Ruth West, 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 and Asthma Center, PC
Patient Registration Form

Patient Name:____ Date completed __________
First Middle Initial Last

Mailing Address ______________________City__________ State________ Zip__________

Phone (_______)__________ May we leave messages with detailed health information and billing questions? __________

May we email you with our quarterly newsletter? Circle one, please: Yes No

Please provide your email address for communication with providers about your healthcare:__________

Primary Physician ______________________Pharmacy______________________

Social Security #______________________ Birthday______________ Age ______ Sex______
Month/Day/Year M/F

Place of Employment ____

Occupation ______________________ Status______________________
Full-time/Part time

Work Phone # ______________________ May we contact you at work? ______________Yes/No
Area Code/Work #/Extension

Marital Status______________ Spouse's Name and Birthdate______________________
Single/Married

Please submit your insurance card or cards for copying.

Primary Insurance______________________ Policy Holder ______________
Name of Insurance Company

Secondary Insurance______________________ Policy Holder ______________
Name of Insurance Company

Is patient age 18+______________ Patient will receive statement unless AAC staff is notified of another person's responsibility
Y/N for payment on account if the answer is "Y".

If "N"
Mother/Guardian Name ______________________ Birthday______________ Age______

Social Security # ______________________ Place of Employment ______________________

Occupation______________________ Work # ______________________ Status ______________
Full-time/Part-time

Address and Phone # if different than Patient ____

Father/Guardian Name ______________________ Birthday______________ Age______

Social Security # ______________________ Place of Employment ______________________

Occupation______________________ Work # ______________________ Status ______________
Full-time/Part-time

Address and Phone # if different than Patient ____

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 QUESTIONAIRE

Name ______________________________ Date of Birth ___________ Age _____ Sex _____ Ethnicity ___________

Who referred you to our department? ___________________ Who do you see regularly? ________________________

Briefly describe the reason for your allergy/asthma visit:

ALLERGY HISTORY: Please check the symptoms you are having.

Nose:	Lungs:	Skin:	Miscellaneous:
Nasal discharge _____	* Chronic cough ______	Eczema ______	Thyroid problems______
Clear _____	* Shortness of breath _____	Hives (welts) _____	Headaches _____
Colored _____	* Wheezing ______	Dry skin ______	Irritability _____
Sneezing _____	* Tightness in Chest _____	Frequent Rashes _____	Hard to awaken ______
Sniffing _____	* If yes, note box below		Tires easily ______
Post nasal drip ______		**Eyes:**	Poor weight gain _____
Congestion _____	Exercise Intolerance _____	Redness ______	Weight loss ______
Mouth breathing _____	Sputum or Phlegm ______	Tearing ______	Fevers______
Nasal voice _____	Pneumonia ______	Itching ______	Chills ______
Snoring _____	Bronchitis ______	Swelling ______	Night sweats ______
Polpys ______	Frequent Colds ______		Joint/muscle problems ______
Can't taste/smell ______	Frequent Croup ______	**GI:**	Fainting/dizzy _____
Nosebleeds ______	**Throat:**	Heartburn _____	Depression _______
Ears:	Itching _____	Nausea _____	Anxiety ______
Frequent ear infections ____	Sore throats _____	Vomiting _____	Painful urination _____
Ear tubes/fluid _______	Throat clearing _____	Diarrhea _____	Abnormal periods _____
Ear pain _____	Bad breath _____	Constipation _____	Heart trouble ______
Hearing loss ______	Hoarse voice _______	Greasy fatty stools ___	Easy bruising _______
Speech problems ______		Difficulty swallowing ___	

* Cough: Waking up in the AM _____ Throughout the day _____ Awakened at night _____
With exercise _____ Dry and tight _____ Productive _____
How often: daily _____ 3 times a week _____ once a week _____ once a month _____
* Shortness of breath: During exercise _____ While resting ______ Awakened at night _____
* Wheezing/Chest tightness: With exercise _____ Awakened at night _____ With colds _____

How long have you (the patient) had these symptoms? ___________ Time missed from school/work in the last year? __________

Have you (the patient) ever been treated emergently for an allergic reaction? Y N Explain: ______________________

Have you (the patient) been tested for allergies? Y N What year? __________ Findings? ______________________

Have you (the patient) received allergy shots? Y N If yes, did they help? Y N

Do you (the patient) have any problems eating certain foods? Y N If yes, please list:_________________________
____

Have you ever had an allergic reaction to a stinging insect? Y N If yes, please list ______________________

Which of the following make your symptoms worse?

_____ Spring	_____ Morning	_____ Smoke	_____ Indoors	_____ Dust
_____ Summer	_____ Afternoon	_____ Strong odors	_____ Outdoors	_____ Mold
_____ Fall	_____ Evening	_____ Cold air	_____ Basement	_____ Plants/grasses
_____ Winter	_____ While Sleeping	_____ Weather changes	_____ Work/school	_____ Animals
_____ Colds/flu	_____ Exercise	_____ Wind	_____ Rain	_____ Emotions

Medications

List all medications that you are taking. Include those you buy / use without a prescription.

Include dosage and how many times a day you take the medications	

Please bring all of your medications with you to your appointment!!

Are you allergic to any medications? Y N If yes, list medication(s) and reactions: ____________________

____

Past Medical History

Significant childhood illnesses: ____________________

Other medical problems (Diabetes, Heart Disease, Kidney Disease, High Blood Pressure, Arthritis, Cancer, etc) :

____

Hospitalizations: Y N If yes, specify and give year: ____________________

Surgeries: Y N If yes, specify and give year: ____________________

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

Chest X-Ray? ____________ Sweat test? ____________ Breathing test? ____________

Sinus X-rays or CT Scan? ____________ Cardiac tests (EKG, echo, stress test) ____________

Do you (the patient) have a history of ?

_____ Asthma	_____ Eczema	_____ Food reactions	_____ Tuberculosis
_____ Hayfever	_____ Rashes	_____ Drug reactions	_____ Migraine headaches
_____ Frequent colds	_____ Hives or swelling	_____ Insect reactions	_____ Bee sting reactions
_____ Sinus infections	_____ Skin infections	_____ Croup	_____ Bronchiolitis/RSV
_____ Ear infections	_____ Pneumonia	_____ Bronchitis	_____ Latex Allergy

Are any of these recurring? N Y Explain: ____________________

____

Immunizations:

Are your (the patient) immunizations up-to-date? Y N Do you receive an annual flu vaccine? Y N

Have you had (a): Pneumonia shot? Y N TB Skin Test: Y N Chicken Pox? Y N

Birth History : Birth weight ____________ Complications? ____________________

As an infant did you (the patient) have: Colic ______ Eczema ______ Many formula changes ______

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

Family History

Mother: Age if living _____ Good Health / Medical Problems: ______________________________
Age at death __________ cause of death ______________________________

Father: Age if living _____ Good Health / Medical Problems: ______________________________
Age at death __________ cause of death ______________________________

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

	Asthma	Hayfever	Eczema	Hives	Sinus Problems
Mother (M)					
Father (F)					
Sibling (S) (B)					
Sibling (S) (B)					
Child (C)					
Child (C)					
G'parent (GM/GF)					

Autoimmune Disease _______ Heart Disease ______ Emphysema ______ Repeated infections ______
Arthritis ______ High Blood Pressure COPD ______ Cystic Fibrosis _______

Does patient have any children? Y N If yes, list ages and any other medical problems______________________________
____

Does patient have any siblings? Y N If yes, list ages and any other medical problems ______________________________
____

Environmental History

Type of home: House Apartment Mobile home Where: Rural City Edge of town

Age of the home? __________ Number of years in your present home? ______________

Heat: Gas furnace Gas fireplace Oil Electric Hot water Wood furnace Wood stove Wood fireplace

Air Conditioning? Y N Central _____ Window _____ Swamp cooler ______ Dehumidifier? Y N

Air Cleaner? Y N What type? ____________________ Humidifier? Y N Do you change the filters regularly? Y N

Home Flooring: (circle all that apply) Wood Carpet Vinyl Tile

Patient's Bedroom: Flooring ______________ Is it a basement bedroom? Y N

Mattress: How old? _______ Encased in an allergy cover? Y N

Pillow: How old? _______ Encased in an allergy cover? Y N Synthetic / Feather

Stuffed animals? Y N

Household plants: Y N How many? __________ In bedroom ? Y N

Indoor pets: Y N Which ones: ______________________________

Pets in bedroom: Y N Which ones: ______________________________

Do other members of the household smoke? Y N Who: ______________________

Does anyone smoke in the house or car? Y N Who: ______________________

Occupational / Social History

Place of birth: ______________________ How long have you lived in Western Montana? ____________

School: Is patient in school? Y N Grade: ______ Where? ______________________

Smoking history: Do you (the patient) smoke? Y N Year started: ________ #/day: ____________

Did you smoke in the past? Y N Year quit: __________ #/day: __________

Does patient use chewing tobacco? Y N ______________________

Does patient drink alcohol regularly? Y N ______________________

Does patient use any illegal drugs? Y N ______________________

Employment: Do you work? Y N Where? ______________________

Gas, dust, chemical or fume exposure: Y N

Past employment exposures: ______________________

Recent travel: Y N If yes, when and where: ______________________

Hobbies: Y N Please list: ______________________

Complete if the patient is a child:

Childcare: Does patient go to daycare? Y N # of children at daycare: ________

Pets at daycare? Y N Which ones: ____________

Second hand smoke at daycare? Y N

Mother's Name: ________________ Occupation/Place of Employment: ________________

Father's Name: ________________ Occupation/Place of employment: ________________

Circle the answers that best describe your family.

My natural parents are: married not married divorced widowed remarried

If parents do not live in the same household, how much time is spent with each parent? ________________

# of siblings: ____________

Additional notes or concerns:

Thank you for taking time to complete this form.

Map of:
900 N Orange St
Missoula, MT 59802-2998

Notes

From Interstate 90 take the Orange St. exit. We are located immediately on the left next to the Providence Surgery Center. From South of Missoula, take Hwy 93 to Stephens Ave. Go left at the light onto Stephens Ave. Stephens becomes Orange St. Continue on Orange St under the underpass. We are on the right.

©2012 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. View Terms of Use