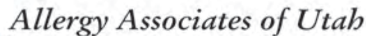

Fashion Place Location
6095 Fashion Boulevard, Suite 100
Murray, Utah 84107
801-263-8700 • Fax 801-263-8693

Jordan Landing Location
3855 West 7800 South, Suite 225
West Jordan, Utah 84088
801-282-8700 • Fax 801-282-3305

Thank you for choosing Allergy Associates of Utah for your medical care.

Please complete the included allergy questionnaire and return it by mail (if time permits) or bring it with you to your appointment. If you do not have time to complete it before your appointment, please arrive at our office at least 30-45 minutes early so you will be ready in time for your appointment. If you would like to send in your paperwork or any additional medical records electronically, please contact our office, and the staff will walk you through the process.

Please make sure to bring a current copy of all active insurance card(s) and your identification/driver's license to the appointment.

AN ALLERGY EVALUATION CAN TAKE UP TO TWO-THREE HOURS. Please do not schedule any other appointments that may conflict with your allergy appointment.

The provider may perform testing to evaluate your medical condition. The type and number of tests may vary depending on the medical problem.

If testing needs to be performed, you should **AVOID** the following allergy medications for the specified times:

- Claritin (Loratadine), Allegra (Fexofenadine), Zyrtec (Cetirizine), Clarinex, Xyzal, Hydroxyzine, Vistaril – **72 hours**
- Benadryl (Diphenhydramine), Lodrane (Bromphenaramine), Chlorpheniramine, DAllergy, Allerx – **48 hours**
- Any other antihistamine or anti-itch pill, cough/cold medication, or allergy pill – **Check with the office**
- Astelin (Azelastine), Astepro, Dymista, or Patanase (Olapatadine) Nasal Spray – **48 hours**
- Patanol (Olapatadine), Pataday, Zaditor (Ketotifen), Optivar (Azelastine), Elestat (Epinastine), or other anti-histamine allergy eye drops – **48 hours**
- Zantac (Ranitidine), Pepcid (Famotidine) – **48 hours**

YOU SHOULD NOT STOP ANY OTHER MEDICATIONS, INCLUDING ASTHMA MEDICATIONS, STEROIDS, OR ANTIBIOTICS, UNLESS DIRECTED BY A HEALTH CARE PROVIDER. If you have any questions, please call our office before your appointment.

We routinely contact your insurance for a good-faith estimate of your benefits for our most routine tests and procedures. We will discuss with you when these tests may be medically beneficial.

Copayments for specialist office visit services are due at time of service and/or a good-faith estimate of your deductible and coinsurance as determined by your medical plan at the time of service. Any questions or payment arrangements can be made with the Business Office prior to your visit at (801)263-8700, option 1.

Please notify our office at least 24-48 hours before your appointment if you are unable to keep it. We look forward to meeting you and helping you with your medical care.

Sincerely,

Allergy Associates of Utah
www.utahallergies.com
office@utahallergies.com

ALLERGY ASSOCIATES OF UTAH

Patient Information

Name: ______________________________ Date of Birth: ____ / ____ / ______ Date: ____ / ____ / ______

Address: ______________________________ City: ______________ State: ________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Occupation: ______________________________

Emergency Contact: ____

Relationship: ______________ Phone: ______________ Address: ______________________________

Personal Physician: ______________________________ Referred by: ______________________________

Please list other family members who have been seen in this practice: ______________________________

Responsible Party

IF THE PATIENT IS AN **ADULT**	IF THE PATIENT IS A **MINOR**
Employer: ______________________	Responsible party name: ______________________
Work Phone: ______________________	Address: ______________________
Spouse: ______________________	City: ______________ State: ________ Zip: ________
Employer: ______________________	Home Phone: ______________________
Work Phone: ______________________	Employer: ______________________

Insurance Information

1st Insurance Company: ______________________	2nd Insurance Company: ______________________
Subscriber Name: ______________________	Subscriber Name: ______________________
Subscriber Date of Birth: ______________________	Subscriber Date of Birth: ______________________
Subscriber ID#: ______________________	Subscriber ID#: ______________________
Subscriber Group#: ______________________	Subscriber Group#: ______________________

NOTE: IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, PLEASE GIVE YOUR CURRENT, COMPLETED REFERRAL FORMS FROM YOUR PRIMARY CARE PHYSICIAN AS WELL AS YOUR INSURANCE ID CARD TO THE FRONT DESK BEFORE YOU SEE THE DOCTOR. IT IS YOUR RESPONSIBILITY TO COMPLY WITH THE TERMS OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY.

CREDIT POLICIES

1. PAYMENT IS REQUESTED AT THE TIME OF TREATMENT UNLESS SPECIAL ARRANGEMENTS ARE MADE.
2. PAYMENT ON ACCOUNTS BILLED IS EXPECTED WITHIN 30 DAYS.

No finance charge will be made unless the account is not discharged as per agreement. I/We acknowledge this agreement and agree to pay collection costs and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection suit.

Patient/Parental Signature: ____ Date: ____ / ____ / ________

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Allergy Questionnaire

Patient Name: ____ Date of Birth: ____ / ____ / ______ Date: ____ / ____ / ______

Describe the typical symptoms in your own words:

____
____
____
____
____

Have you had previous allergy testing? ☐ No ☐ Yes (When and by whom): ____

Please fill out the following sections:

1. Allergies (Nose, Eyes, Sinuses) ☐ Does not apply

Symptoms	How often?					How bad?		
	Never	Rarely	Some days	Most days	Daily	Mild	Moderate	Severe
Nasal congestion	☐	☐	☐	☐	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐	☐	☐	☐	☐
Post-nasal drip	☐	☐	☐	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐
Eye itch	☐	☐	☐	☐	☐	☐	☐	☐
Eye watering	☐	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐	☐
Ear symptoms	☐	☐	☐	☐	☐	☐	☐	☐

Allergy Triggers:

☐ Trees ☐ Grass ☐ Weeds ☐ Mold
☐ Cats ☐ Dogs ☐ Dust ☐ Horses
☐ Strong odors/chemicals ☐ Cold air ☐ Exercise ☐ Infection
☐ Winter ☐ Spring ☐ Summer ☐ Fall
☐ Other: ☐ Unknown ☐ NONE

08/01/2016

Patient Name: ____ Date of Birth: ____ / ____ / ______

2. Breathing

☐ Does not apply

I have: ☐ Breathing symptoms ☐ Asthma ☐ COPD ☐ Other

Symptoms	How often?					How bad?		
	Never	Rarely	Some days	Most days	Daily	Mild	Moderate	Severe
Shortness of breath	☐	☐	☐	☐	☐	☐	☐	☐
Chest tightness	☐	☐	☐	☐	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐

Breathing Triggers:

☐ Trees ☐ Grass ☐ Weeds ☐ Mold
☐ Cats ☐ Dogs ☐ Dust ☐ Horses
☐ Strong odors/chemicals ☐ Cold air ☐ Exercise ☐ Infection
☐ Winter ☐ Spring ☐ Summer ☐ Fall
☐ Other: ☐ Unknown ☐ NONE

3. Food Reactions

☐ Does not apply

What now or in the past has caused trouble?

____

____

What was the reaction?

____

____

4. Rashes and Hives

☐ Does not apply

What now or in the past has caused trouble?

____

____

What was the reaction?

____

____

5. Insect Sting Reactions

☐ Does not apply

Has the patient ever had a severe reaction to a bee, wasp, or hornet sting?

☐ No

☐ Yes (Describe): ____

Patient Name: ________________________________ Date of Birth: ____ / ____ / ______

Medical, Family, and Social History

1. Medical Problems and Surgeries

Please check any of the following medical problems or surgeries that you have had:

Medical Problems	
☐ NONE	
☐ Asthma	☐ Migraines
☐ COPD	☐ Arthritis
☐ Tuberculosis	☐ Rheumatoid arthritis
☐ Allergies	☐ Depression
☐ Nasal polyps	☐ Anxiety
☐ Chronic sinusitis	☐ Other psychiatric
☐ Reflux/heartburn	☐ Heart disease
☐ Peptic ulcer disease	☐ Heart attack
☐ Low thyroid	☐ Heart failure
☐ High thyroid	☐ Chest pain
☐ High blood pressure	☐ Stroke
☐ High cholesterol/lipids	☐ Transient stroke
☐ Diabetes	☐ Cancer
☐ Kidney stones	
☐ Other:	

Surgeries	
☐ NONE	
☐ Sinus	☐ Heart valve
☐ Nasal polyp	☐ Cataract
☐ Nasal septum	☐ Colon scope
☐ Other nose surgery	☐ Gastric bypass
☐ Tonsils	☐ Intestinal surgery
☐ Adenoids	☐ Hernia repair
☐ Ear tubes	☐ Hemorrhoids
☐ Appendix	☐ Breast biopsy
☐ Gallbladder	☐ Breast augmentation
☐ Thyroid	☐ Breast removal
☐ Hysterectomy	☐ Hip
☐ D&C	☐ Knee
☐ Caesarean section	☐ Back
☐ Heart bypass	
☐ Other:	

2. Family History

Please check and list any medical problems that run in your family:

	No Problems	Unknown	Allergies	Asthma	Food Allergies	Eczema	Other (Please list)
Father	☐	☐	☐	☐	☐	☐	
Mother	☐	☐	☐	☐	☐	☐	
Brothers (☐ none)	☐	☐	☐	☐	☐	☐	
Sisters (☐ none)	☐	☐	☐	☐	☐	☐	

3. Social History

Housing Type:
- ☐ Apartment
- ☐ Single family home
- ☐ Condo
- ☐ Other: ____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other

Occupation: ____

Do you smoke?
- ☐ No
- ☐ Yes -> For how long? ______________________________
  How many packs per day? _______________________
- ☐ Former -> When did you quit? _______________________
  How long did you smoke? _______________________
  How many packs per day? _______________________

Do you drink alcohol?
- ☐ No
- ☐ Yes
- ☐ Former

Any pets at home?
- ☐ No
- ☐ Yes
  - ☐ Cat(s)
  - ☐ Dog(s)
  - ☐ Other: _______________________________

Do you have a primary care physician?
- ☐ No
- ☐ Yes: ____

Did a physician refer you?
- ☐ No
- ☐ Yes: ____

How did you hear about us? ____

Patient Name: ____ Date of Birth: ____ / ____ / ______

Medication Allergies and Medications

Please list any reactions to medications: ☐ NONE

Medication Name	Reaction	Approximate Date / Age

Please list any medications you are currently taking: ☐ NONE

Medication Name	Strength	Dose	Frequency

NOTES

____

____

____

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MEDICAL & FINANCIAL INFORMATION AUTHORIZATION & RELEASE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual 's office instead of the individual's home. We will release information ONLY by the authorized means you have chosen. We will take reasonable steps to limit the use or disclosure of and request for PHI co the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. We will keep a record of all PHI disclosures. Uses and disclosures may be permitted without prior consent in an emergency.

I authorize the staff of Allergy Associates of Utah to release any **financial** information to the following people:

Name of Spouse: ____
Partner: ____
Parent or Guardian: ____
Other: ____

I authorize the staff of Allergy Associates of Utah to release any **medical** information to the following people:

Name of Spouse: ____
Partner: ____
Parent or Guardian: ____
Other: ____

Please check all that apply:

Telephone Communication:	Written Communication:
☐ Home telephone:	☐ OK to mail to my home address
☐ Cell phone:	☐ OK to mail to my work/office address
☐ OK to leave detailed message on answering machine	☐ OK to fax to this number:
☐ OK to leave message with call back number only	☐ OK to mail promotional material
☐ Work telephone:	☐ OK to mail information regarding research studies
☐ OK to leave detailed message on answering machine	☐ Other/list any restrictions:
☐ OK to leave message with call back number only	

I have received the Notice of Privacy Practices of Allergy Associates of Utah and I have been provided an opportunity to review it. I understand l may revoke any part of this authorization at any time by giving written notice to the Privacy/Security Officer at Allergy Associates of Utah.

Patient (or legal representative) name: ____

Signature: ____ Date: ____ / ____ / ______

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Electronic Communication Policy

Patient Name: ______________________________ Date of Birth: ___ / ___ / _____ Date: ___ / ___ / _____

☐ I would like to sign up for the **Onpatient patient portal** and receive e-mail reminders for my clinical care.

E-mail address to be used: ____

☐ I would like to receive text message reminders for my clinical care.

Phone number to be used: ____

☐ I **DECLINE** electronic communication.