

BAKER ALLERGY, ASTHMA & DERMATOLOGY
Be sure to complete both sides

ACCOUNT _____	DATE _____	NEW / UPDATED _____
PATIENT'S FULL NAME _____	BIRTHDATE: _____	SEX: M / F _____
STREET ADDRESS _____	SOC SEC # _____	
CITY/STATE/ZIP _____	DRIVER'S LIC. # _____	
OCCUPATION _____	HOME PHONE _____	CELL PHONE _____
EMPLOYER _____	WORK PHONE _____	EXTENSION _____
EMAIL ADDRESS _____	FAX NUMBER _____	
SPOUSE/RESPONSIBLE PARTY _____ RELATIONSHIP _____		
STREET ADDRESS _____ SOC SEC# _____		
CITY/STATE/ZIP _____ HOME PHONE _____		
OCCUPATION _____ CELL PHONE _____		
EMPLOYER _____ WORK PHONE _____		
NEAREST (LOCAL) RELATIVE/FRIEND (NOT LIVING WITH YOU) TO CALL IF WE CANNOT REACH YOU		
NAME _____	RELATIONSHIP _____	HM PHONE _____ WK PHONE _____
IMPORTANT: PLEASE COMPLETE ALL INSURANCE INFORMATION AND PROVIDE A COPY OF INSURANCE CARD		
PRIMARY INS CO _____	SECONDARY INS CO _____	
SUBSCRIBER'S NAME _____	SUBSCRIBER'S NAME _____	
SUBSCRIBER'S DATE OF BIRTH _____	SUBSCRIBER'S DATE OF BIRTH _____	
ID# / SOC SEC # _____	ID# / SOC SEC # _____	
GROUP # _____ EFFECTIVE DATE _____	GROUP # _____ EFFECTIVE DATE _____	
SUBSCRIBER'S EMPLOYER _____	SUBSCRIBER'S EMPLOYER _____	
As a service to our patients, we will gladly bill your primary and secondary insurance for you with a copy of your insurance card.		
PRIMARY CARE DOCTOR _____	PHONE # _____	
STREET ADDRESS _____	CITY/STATE/ZIP _____	
Does this provider request a report to be sent to him / her? Y / N		
HEALTHCARE SPECIALIST _____	PHONE # _____	
STREET ADDRESS _____	CITY/STATE/ZIP _____	
Does this provider request a report to be sent to him / her? Y / N		
How did you hear about us? <input type="checkbox"/> Yellow pages <input type="checkbox"/> Sign <input type="checkbox"/> Insurance <input type="checkbox"/> Newspaper <input type="checkbox"/> Website <input type="checkbox"/> PCP <input type="checkbox"/> Other		
CONTACT AUTHORIZATION: I hereby authorize Baker Allergy, Asthma & Dermatology to leave a voicemail regarding visits, and any results needing communicated at the phone number provided below.		
Phone: _____		
CONTACT AUTHORIZATION: I hereby authorize Baker Allergy, Asthma & Dermatology to send an email regarding visits, and any results needing communicated at the email address provided below.		
Email: _____		
Signature authorizing the above statement(s): _____		
(if patient is a minor, signed by parent or legal guardian)		
<u>Updated Information:</u>		
Date/Initial _____	Date/Initial _____	Date/Initial _____
Date/Initial _____	Date/Initial _____	Date/Initial _____
Office Use ONLY:		
COPAY _____	CLINIC _____	INITIALS _____

BAKER ALLERGY, ASTHMA & DERMATOLOGY

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PATIENTS RESPONSIBILITY FOR PAYMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Baker Allergy, Asthma & Dermatology will submit charges for medical treatment to the patient's insurance company and where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.

Baker Allergy, Asthma & Dermatology does not verify in advance the patients insurance. Patients should contact their insurance companies directly for any coverage questions they may have. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay.

If the patient participates in an Oregon Health Plan program, the patient will be responsible for payment of services related to conditions that are not covered by the Plan. If the patient participates in Washington DSHS, the patient will be responsible for all services. Baker Allergy, Asthma & Dermatology does not accept Washington DSHS.

Baker Allergy, Asthma & Dermatology does not treat worker's compensation injuries or illnesses. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at Baker Allergy, Asthma & Dermatology for medical care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred.

Patient Responsibility (Disclaimer)

I understand that my insurance plan _____ can require a referral from my Primary Care Physician in order to cover the visits to a Specialty Physician. If Baker Allergy, Asthma & Dermatology at this time has not received verification that a referral was obtained for services, and, if my insurance company denies payment, I agree that I will be financially responsible for any and all charges incurred (including lab and x-ray).

If the patient participates in an HMO or PPO that requires co-payment, the patient must pay the co-payment at the time of the appointment.

I hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and the physician to release to the insurance company any information acquired in the course of my examination and treatment.

<p>AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Baker Allergy, Asthma & Dermatology and the above physician to release to the insurance company named above any information acquired in the course of my examination or treatment</p> <p>SIGNED _____ (if patient is a minor, signed by parent or guardian)</p>	<p>ASSIGNMENT OF INSURANCE BENEFITS: I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due me to the fullest extent of my financial obligation to said office.</p> <p>SIGNED _____ (if patient is a minor, signed by parent or guardian)</p>
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Patient Signature (Parent or Guardian if patient is a minor)

Date

Patient Printed Name

NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of you medical information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AD DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

We may use or disclose to others your medical information for the purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

At Baker Allergy and Asthma we have several patients at one time being tested for allergies. When this occurs, you may be visible by other patients and may be able to be overheard when speaking with the nurses. We do maintain your privacy as much as possible during your treatment.

We also provide allergy shots in our shot clinic where you sign in and are called for treatment, Though we have curtains to restrict the view of other patients, others may be able to see and/or hear conversations with your nurse. We will maintain your privacy as much as physically possible during your treatment.

By: _____ Date: _____
(patient)

OR

By: _____ Date: _____
(patient representative)

Description of Representative's Authority: _____

**Baker Allergy and Asthma
Allergy Evaluation with Dr James Baker**

Name _____ male/female Age _____

Date _____

Name of Doctor referring you _____

What do you want to get out of this doctor visit?

What problems do you want to discuss today and what medications are you taking for each of these problems?

1.

2.

3.

List all other medications you are currently taking and for what problem:

Do you have any medication allergies: yes, please list or NONE

Have you ever had any of the following? If yes please circle

Asthma	Seasonal Allergies	Food Allergies	Bee sting allergies
Hepatitis	Herpes	Tuberculosis	Eczema
Psoriasis	Immune disease	Heart problems	Depression
Cancer	Diabetes	High Blood pressure	Stomach problems
Glaucoma	Seizures	Food intolerance	Skin problems

List any surgical procedures you have had and the year:

Total Nasal Symptom Score for _____ Date _____

Circle the points that best match your answer

1. Please rate how your nasal congestion symptoms have been over the past 12 hours Last 2 weeks

None	0	0
Mild (symptoms clearly present but easily tolerated)	1	1
Moderate (symptoms are bothersome but tolerable)	2	2
Severe (symptoms are hard to tolerate – causes interference with activities of daily living and/or sleeping)	3	3

2. Please rate how your runny nose symptoms have been over the past 12 hours Last 2 weeks

None	0	0
Mild (symptoms clearly present but easily tolerated)	1	1
Moderate (symptoms are bothersome but tolerable)	2	2
Severe (symptoms are hard to tolerate – causes interference with activities of daily living and/or sleeping)	3	3

3. Rate how your nasal itching symptoms have been over the past 12 hours Last 2 weeks

None	0	0
Mild (symptoms clearly present but easily tolerated)	1	1
Moderate (symptoms are bothersome but tolerable)	2	2
Severe (symptoms are hard to tolerate – causes interference with activities of daily living and/or sleeping)	3	3

4. Rate sneezing symptoms over the past 12 hours Last 2 weeks

None	0	0
Mild (symptoms clearly present but easily tolerated)	1	1
Moderate (symptoms are bothersome but tolerable)	2	2
Severe (symptoms are hard to tolerate – causes interference with activities of daily living and/or sleeping)	3	3

5. Rate how difficult it was to sleep last night due to nasal symptoms times you wake up

None	0	0
Little difficulty falling to sleep. Woke up once	1	1
Moderate awoke more than once due to nasal symptoms	2	2
Severe very difficult to fall asleep. Awake most of the night	3	3

Total points from the above 5 areas _____

Asthma Control Test for _____ Date _____

Circle the points that best match your answer:

1. In the past four weeks, how much of the time did your asthma keep you from getting as much done at work or at home?

Points

None of the time	1
A little of the time	2
Some of the time	3
Most of the time	4
All of the time	4

2. During the past four weeks, how often have you had shortness of breath?

Not at all	1
Once or twice a week	2
3-6 times a week	3
Once a day	4
More than once a day	5

3. During the past four weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

Not at all	1
Once or twice	2
Once a week	3
2-3 nights a week	4
4 or more nights a week	5

4. During the past four weeks, how often have you used your rescue inhaler or nebulizer medication (such as Albuterol, Ventolin, Proventil, Maxair or Primatene Mist) for rescue? Do not count pre-exercise use.

Not at all	1
Once a week or less	2
2-3 times per week	3
1-2 times per day	4
3 or more times per day	5

5. How would you rate your asthma control during the last four weeks?

Completely controlled	1
Well controlled	2
Somewhat controlled	3
Poorly controlled	4
Not controlled at all	5

Total points from the above 5 areas _____