Allergy & Asthma Center

of Southern Oregon, PC

Edward M. Kerwin, MD KevinW. Parks, MD
Jennifer K. Milligan, PA -C JalehOstovar, FNP-C

PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION:

Date: _____

Patient Name: _____ **DOB:** _____ **Age:** _____ **M/F**
First M Last

Mailing Address: _____
Street City State Zip Code

Home Ph: _____ **Cell Ph:** _____ **Work Ph:** _____

E-Mail: _____ **How would you prefer to be contacted?** Home ❑ Cell ❑ Work ❑ Email ❑

Language: _____ **Patient's Ethnicity:** **Hispanic/Latino**_____ **Non-Hisp/Latino**_____ **Other**_____

Patient's Race (mark all that apply): Caucasian____ African American____ Asian____ American Indian____ Other____ Unknown____

Primary Care Provider: _____ **Referring Provider:** _____

PERSON RESPONSIBLE FOR PATIENT:

Mother's Name: _____ **DOB:** _____ **SSN:** _____
First M Last

Address (if different than patient): _____

Home Ph: _____ **Cell:** _____ **Work:** _____

Employer: _____ **Emp Ph:** _____ **Emp Address:** _____

Father's Name: _____ **DOB:** _____ **SSN:** _____
First M Last

Address (if different than patient): _____

Home Ph: _____ **Cell:** _____ **Work:** _____

Employer: _____ **Emp Ph:** _____ **Emp Address:** _____

INSURANCE COVERAGE:

Primary Insurance: _____ **Address:** _____

Name of Policy Holder: _____ **DOB:** _____ **SSN:** _____
First M Last

ID Number: _____ **Group Name:** _____ **Relationship to Patient:** _____

Secondary Insurance: _____ **Address:** _____

Name of Policy Holder: _____ **DOB:** _____ **SSN:** _____
First M Last

ID Number: _____ **Group Name:** _____ **Relationship to Patient:** _____

AUTHORIZATION TO PAY AND RELEASE INFORMATION:

I realize it is the **patient or guardian's responsibility** to be aware of what is/is not covered by my insurance. The contract of insurance is between me and my insurance company, and I should clarify benefits with my insurer if any questions. I am ultimately responsible for payment of the services provided me. I hereby assign all medical and/or surgical benefits for initial and follow-up Allergy & Asthma Center (AAC) visits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to AAC. This assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Parent/Guardian: _____ **Date:** _____

Allergy & Asthma Center

of Southern Oregon, PC
Edward M. Kerwin, MD KevinW. Parks, MD
Jennifer K. Milligan, PA -C JalehOstovar, FNP-C

PATIENT REGISTRATION

PATIENT INFORMATION:

Date: _____

Patient Name: _____ **DOB:** _____ **Age:** _____ **M/F**
First M Last

Mailing Address: _____
Street City State Zip Code

Home Ph: _____ **Cell Ph:** _____ **Work Ph:** _____

Employer: _____ **Emp Ph:** _____ **Emp Address:** _____

E-Mail: _____ **How would you prefer to be contacted?** Home ❑ Cell ❑ Work ❑ Email ❑

Marital Status: **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Other** ❑ _____

Language: _____ **Patient's Ethnicity:** **Hispanic/Latino**_____ **Non-Hisp/Latino**_____ **Other**_____

Patient's Race (mark all that apply): Caucasian____ African American____ Asian____ American Indian____ Other____ Unknown____

Emergency Contact: _____ **Relationship:** _____ **Emergency Phone:** _____

Ok to speak to: _____ **Medications:**_____ **Labs:**_____ **Appts:**_____

Primary Care Provider: _____ **Referring Provider:** _____

INSURANCE COVERAGE:

Primary Insurance: _____ **Address:** _____

Name of Policy Holder: _____ **DOB:** _____ **SSN:** _____
First M Last

ID Number: _____ **Group Name:** _____ **Relationship to Patient:** _____

Employer: _____ **Emp Ph:** _____ **Emp Address:** _____

Secondary Insurance: _____ **Address:** _____

Name of Policy Holder: _____ **DOB:** _____ **SSN:** _____
First M Last

ID Number: _____ **Group Name:** _____ **Relationship to Patient:** _____

Employer: _____ **Emp Ph:** _____ **Emp Address:** _____

AUTHORIZATION TO PAY AND RELEASE INFORMATION:

I realize it is the patient or guardian's responsibility to be aware of what is/is not covered by my insurance. The contract of insurance is between me and my insurance company, and I should clarify benefits with my insurer if any questons. I am ultimately responsible for payment of the services provided me. I hereby assign all medical and/or surgical benefits for initial and follow-up Allergy & Asthma Center (AAC) visits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to AAC. This assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient: _____ **Date:** _____

Allergy & Asthma Center of Southern Oregon, PC
Edward M. Kerwin, MD Kevin W. Parks, MD Jennifer K. Milligan, PA-C Jaleh K. Ostovar, FNP-C
Appointments: 1.888.558.1003 Fax: 541.857.4499

Patient Questionnaire

Today's Date: _____ **Home Phone:** _____ **Cell Phone:** _____

Name: _____ **DOB:** _____ **Age:** _____ M F
Occupation: _____ **School:** _____ **Hobbies:** _____
Personal Information: _____
Ok to upload medications from your pharmacy: Y N **Pharmacy:** _____

Current Medical Symptoms (Circle all that apply):

Nasal Congestion	Itchy Eyes	Day Cough	Asthma or w/Exercise	Eczema	Headache
Post Nasal Drip	Watery Eyes	Night Cough	Wheezing	Skin Rash	Snoring
Sneezing	Reddened Eyes	Productive Cough	Shortness of Breath	Hives	Sleep Problems

Triggers for Symptoms (Circle all that apply): Dust Trees Grasses Weeds Pets Molds/Mildew Smoke Odors Perfumes Pollution

Circle Most Bothersome Months: **Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec**

Past Medical History (Circle all that apply):

Chronic Skin Disease	Asthma/Emphysema	Gastric Reflux (heartburn)	Depression
Headaches	Other Lung Disease	Intestinal Problems	Anxiety
Seizures/Strokes	High Blood Pressure	Diabetes	Chronic Fatigue Syndrome
Glaucoma	Heart Disease	Thyroid Problems	Fibromyalgia
Ear Tubes (Surgery?)	Hepatitis/Jaundice	Nasal Polyps (Surgery?)	

Other Conditions: _____

Food Intolerances: None Milk Eggs Wheat Corn Shellfish Fruits Nuts Others: _____
Insects Reactions: No Reactions Bees Mosquitoes Others: _____
Skin Contactants: No Reactions Poison Oak Metal Jewelry Others: _____
Past Surgical History: _____

Family History (Draw a line between the condition and the family member):
Asthma Hay Fever Eczema Hives Food Allergy Other Allergy Conditions in Family: _____

Mother Father Brother Sister Son Daughter Other Relatives: _____

Environmental History (Circle most bothersome months): **Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec**
Lived in present home: Yrs: _____ Age of Home: _____ Location: _____ Year Moved to Oregon: _____
In what geographic area have you spent most of your life? _____

Home Conditions (Circle all that apply):
Present Home: House Apartment Mobile Home Condo Other: _____
Present Home has: Forced Air Heat Wood Stove Wall/Baseboard Heater Air Conditioning
Are there: Damp Areas in Home Mold in the House Moisture under or in House Attic or Basement

Bedroom Products Used (Circle all that apply): Mattress Waterbed Bunk Bed Other: _____
Feather Pillow Feather Comforter Quilt Futon Wool/Electric Blankets Carpeted Window Open at Night: Y N
Do you use dust covers: Pillow: Y N Mattress: Y N

Pet History: Dogs: Y N How Many: _____ Indoors: Y N Outdoors: N Y Do they sleep in Bedroom? Y N
Cats: Y N How Many: _____ Indoors: Y N Outdoors: N Y Do they sleep in Bedroom? Y N
Other Pets or Animals: _____ Do you have exposure to barns or ranch animals? Y N

Are you on Allergy Shots: Y N **Year Started:** _____ **Maintenance** **Building** **Inhalants** **Venom**

Do you take a Beta Blocker: Y N

Smoking History: Did you ever smoke? Y N Year Started: _____ Packs/Day: _____ Did you Quit? Y N When: _____
Does anyone currently smoke inside your home? Y N Who: _____
Alcohol Use: Y N **Exercise:** Y N **Drug Use:** Y N **Aspirin Sensitive:** Y N

Medication Allergies/Intolerances: _____

Signature: _____ **Date:** _____

Allergy & Asthma Center of Southern Oregon, PC
Patient Medication List

Name: _____ Date: _____

Drug Allergies/Intolerances: _____

Prescription Medication	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
Over-the-Counter Medication	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN

Updated 7/13/2015 kmw

Allergy & Asthma Center of Southern Oregon, PC
Clinical Research Institute of Southern Oregon, PC
3860 Crater Lake Avenue, Medford, OR 97504
Phone: (541) 858-1003 Fax: (541) 857-4499

Summary Notice of Privacy Practices**

Dear Patient,

This letter is to provide you a brief summary of our privacy policies. Please take a moment to read through this information. This is provided to continue to serve your medical needs and to comply with federal and state medical privacy rules.

As a patient of our clinics, certain information about you will be collected and kept on file at our office. This information includes: name, date of birth, social security number, insurance information, medical information including, but not limited to, medication lists and diagnostic results, and personal information such as address, phone number and employer information. With your permission we may request records from healthcare professionals that you have seen in the past. We will not disclose this information to outside parties except as authorized by yourself in our Authorization to Use and Disclose Protected Health Information (PHI) form.

You have the right to view any medical information of yours that we hold. In order to receive a copy of your information, you would need to submit a request in writing.

Through your authorization, personnel in our office may view your personal information as required. This includes our medical staff, billing staff, receptionists/schedulers, clinical research staff, and ancillary staff.

As the offices function as a research site, in addition to a medical clinic, our clinical research staff may occasionally view your information in order to determine if you may be eligible for a study. Potentially, you might be contacted regarding a research opportunity.

If you have any questions regarding your privacy rights, please ask any of our staff or contact:

Privacy Officer: Kristen Williams
3860 Crater Lake Avenue
Medford, OR 97504
541.858.1003

I would like a copy of this ***Summary Notice of Privacy Practices*** after I have signed it: Yes_____ No _____

_____ _____
Printed Name of **Patient** Date of Birth

_____ _____
Signature of **Patient** (*or Guardian*) Date

**** I would like a copy of your *Complete Notice of Privacy Practices*: Yes _____ No _____**

_____ _____
Signature Date

09/21/15 kmw

Allergy & Asthma Center
of Southern Oregon, PC
3860 Crater Lake Avenue, Medford, OR 97504
Edward M. Kerwin, MD Kevin W. Parks, MD
Jennifer K. Milligan, PA-C Jaleh K. Ostovar, FNP-C
Appointments: 1-888-558-1003 Fax: 541-857-4499

RECORDS RELEASE FORM

Patient Name: _____ **DOB:** _____

Physician Name: _____

Physician Address: _____

_____

Please release the Medical Records regarding the above patient.

_____ To: **Allergy & Asthma Center of Southern Oregon, PC**
ATTN: Medical Records Dept.
3860 Crater Lake Avenue
Medford, OR 97504

_____ From Allergy & Asthma Center to: _____

_____

_____

We are especially interested in the following information:

_____ *X-Ray Reports*

_____ *EKG Reports*

_____ *Laboratory Reports*

_____ *Summary of Clinical Impression*

_____ *Allergy Test Reports*

_____ *Contents (Formula) of Allergy Extracts used in Immunotherapy*

_____ *Allergy Serums*

_____ *Other:* _____

Patient Signature: _____ **Date:** _____