South Bay Allergy & Asthma Group
A Medical Corporation

Anlin Xu, M.D.
Katharine S. Nelson, M.D.
John S. Kellogg, M.D., M.S.
June Y. Zhang, M.D.

130 Bellerose Drive
San Jose, CA 95128
Phone (408) 286-1707
Fax (408) 286-1744

14981 National Ave, Suite 3
Los Gatos, CA 95032
Phone (408) 358-1771

2500 Hospital Drive, Bldg 11B
Mountain View, CA 94040
Phone (650) 966-8201

100 Arch Street, Suite 2
Redwood City, CA 94062
Phone (650) 362-4643

www.sballergy.com

PATIENT INFORMATION SECTION

CIRCLE ONE MR MRS MISS MS	LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE / /	AGE
STREET ADDRESS				☐ MALE ☐ FEMALE	
CITY		STATE	ZIP CODE	SOCIAL SECURITY #	
HOME PHONE	WORK PHONE	CELL PHONE		EMAIL	

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	HAVE YOU BEEN TREATED BY ANY DOCTOR IN THIS PRACTICE BEFORE? ☐ YES ☐ NO WHEN?
NAME AND ADDRESS OF PRIMARY CARE PHYSICIAN	

EMPLOYER NAME		OCCUPATION	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE
SPOUSE OR PARENT'S NAME	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT ☐ PARENT ☐ SPOUSE ☐ OTHER:	
ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP CODE

EMERGENCY CONTACT

NAME	RELATION TO PATIENT	HOME PHONE	WORK PHONE	CELL PHONE

MEDICAL INSURANCE INFORMATION – PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

☐ SELF PAY

PRIMARY INSURANCE COMPANY ☐ PPO ☐ HMO: _____			SECONDARY INSRUANCE COMPANY ☐ PPO ☐ HMO: _____		
SUBSCRIBER NAME	DATE OF BIRTH	RELATION	SUBSCRIBER NAME	DATE OF BIRTH	RELATION
I.D. NUMBER		GROUP NUMBER	I.D. NUMBER		GROUP NUMBER

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize South Bay Allergy And Asthma Group, Inc. to release any information necessary to process insurance claims relating to the medical care rendered to me or to my dependent by South Bay Allergy And Asthma Group, Inc. I authorize payments of medical benefits to South Bay Allergy And Asthma Group, Inc. for any medical care rendered to me or to my dependents. I understand that I am responsible for any amount not covered or paid by my insurance company(s). I have received a copy of South Bay Allergy And Asthma Group, Inc. "Appointment cancellation policy, insurance policy & cost of procedures".

SIGNATURE _____ DATE _____

CONSENT FOR TREATMENT FOR MYSELF OR A MINOR OR DEPENDENT

I consent and authorize routine and emergency medical treatment for (circle one) me/my child/my dependent when deemed necessary by authorized personnel including doctors at South Bay Allergy And Asthma Group, Inc. This authorization will remain effective unless revoked in writing by me.

SIGNATURE X _____ DATE _____

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MEDICAL QUESTIONNAIRE

Todays' Date: _____

Patient Name: _____ **DOB:** _____ **Age:** _____

How were you referred to SBAAG? _____

Who is your Primary Doctor? (Name & Location) _____

What brings you to SBAAG? (Brief description) _____

Personal Information:

Gender: ☐ Female ☐ Male Place of Birth: _____

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Other (Specify): _____

Occupation: _____ Employer Name: _____

Current Medication:

Please list ALL medications/supplements that you are currently taking (including all that were not prescribed by an MD).

Medication:	Dosage:	How Taken:	Frequency:	Date Started:	Taken For:

☐ Check here if list is continued on another page

Do you have a preferred **Pharmacy**? Name & Location / Phone Number: _____

_____

… more questions on reverse

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MEDICAL QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Allergies:

Medications: ☐ No Known Drug allergies
☐ Penicillin ☐ Sulfa ☐ Other: _____
_____
☐ Check here if list is continued on another page

Foods: ☐ No known Food allergies
☐ Milk ☐ Egg ☐ Shellfish ☐ Wheat
☐ Peanut ☐ Other Foods: _____
_____

Environmental:

Check any that apply to your home environment:

☐ No Pets or Smoke Exposure
☐ Carpet? _____ Bedroom Living Area (circle all that apply)
☐ Air Purifier:_____
☐ Cat(s): How Many? _____ Inside Outside (circle one)
☐ Dog(s): How Many? _____ Inside Outside (circle one)
☐ Other Animals: _____ Inside Outside (circle one)
☐ Dusty: Yes No Medium (circle one)
☐ Humidifier? Yes No (circle one)
☐ Pillow: How Old? _____
☐ Blanket/Comforter: How Old? _____
☐ Mattress: How Old? _____
☐ Trees? Oak olive birch cedar walnut maple elm (circle all that apply)
☐ Trees (other): _____
☐ Length of time in the Bay Area? _____

Family:

Who in your family has had any of these symptoms and/or conditions, currently or in the past?

Allergic Rhinitis/"Hay fever":_____

Asthma: _____

Food Allergies: _____

Eczema: _____

Hives: _____

Sinus disease: _____

Immune deficiency: _____

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MEDICAL QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Operations:

☐ None
☐ Yes, please list below:

What was operated:	What side was operated:	Date of operation:	Surgeon:
☐ Eye			
☐ Sinus, Septum or Nasal			
☐ Knee			
☐ Shoulder			
☐ Abdominal			
☐ Other (please list)			

Past Medical History:

☐ No significant past medical history
☐ Allergies
☐ Asthma
☐ Eczema
☐ Food allergies
☐ Hives (urticaria)
☐ Hypertension
☐ Heart
☐ Diabetes
☐ Thyroid disease
☐ High Cholesterol
☐ Other (please list):

_____ _____
_____ _____

Smoking Status:

☐ Never Smoked
☐ Former Smoker Last smoked? _____ How long did you smoke? _____
☐ Current Smoker How often do you smoke? _____ How long have you smoked? _____
☐ Secondhand smoke exposure? Yes No

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MEDICAL QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Social History:

Are you/your child a student? ☐Yes ☐No What grade/level? _____

Is the patient in childcare (if applicable): ☐Yes ☐No

Alcohol: Do you drink alcohol?

- ☐ No (denies)
- ☐ Heavy
- ☐ Moderate (males: 2 drinks per day / females: 1 drink per day)
- ☐ Occasionally

Immunizations: Have you had a tuberculosis skin test (PPD)? ☐ Yes ☐ No If Yes, was it negative? ☐ Yes ☐ No

Date of test? _____

Do you have an annual flu vaccine? ☐ Yes ☐ No

Have you had a tetanus shot? ☐ Yes ☐ No If Yes, Date? _____

Have you had a pneumococcal vaccine (Pneumovax)? ☐ Yes ☐ No If Yes, Date?_____

Diagnostic Studies:

Have you had a Chest X-ray or Cat-Scan (CT)? _____

Which Study? ☐ X-Ray ☐ Cat-Scan (CT) When? _____

Where was it done? ☐ VRI ☐ Other: _____

Have you had a Sinus X-ray or Cat-Scan (CT)? _____

Which Study? ☐ X-Ray ☐ Cat-Scan (CT) When? _____

Where was it done? ☐ VRI ☐ Other: _____

Questionnaire Filled out by: ☐ Patient

☐ Parent: Father Mother Name:_____

☐ Other: Relation _____ Name:_____

Office use: Entered into system by: _____

If you have filled out this questionnaire prior to your appointment please return by fax to: 408-286-1744

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Todays' Date: Report Date

REVIEW OF SYSTEMS QUESTIONNAIRE

Patient Name: Patient Name **DOB:** Date of Birth **Age:** Age

Are you currently experiencing of have recently experienced any of the following: (please check all that apply to you)

1. General:
- □ Weight gain or loss
- □ Fatigue
- □ Fever/chills
- □ Sleep disturbance

2. Eyes:
- □ Blurred Vision
- □ Decreased vision
- □ Eye pain or itching

3. ENT (Ears/Nose/Throat):
- □ Nasal congestion/itching
- □ Nosebleeds
- □ Sinus pain/pressure
- □ Difficulty swallowing
- □ Mouth sores or thrush

4. Respiratory:
- □ Cough
- □ Wheeze
- □ Shortness of breath
- □ Coughing up blood
- □ Snoring

5. Allergy
- □ Nasal congestion
- □ Nasal drainage
- □ Itchy skin
- □ Itchy/red eyes
- □ Itchy nose
- □ Rash

6. Cardiovascular:
- □ Chest pain or tightness
- □ Palpitations
- □ Shortness of breath with activity
- □ Difficulty sleeping lying down

7. Gastrointestinal:
- □ Abdominal pain
- □ Nausea or vomiting
- □ Diarrhea
- □ Constipation
- □ Heartburn or acid reflux

8. Genital/Urinary:
- □ Infections
- □ Stones

9. Endocrine:
- □ Increased appetite or thirst
- □ Increased urination
- □ Always hot or cold
- □ Hair loss

10. Musculoskeletal:
- □ Weakness
- □ Joint pain or swelling
- □ Back Pain

11. Skin:
- □ Rash
- □ Itching
- □ Dryness
- □ Hair/nail changes

12. Neurologic:
- □ Headaches
- □ Dizziness/Faintness
- □ Numbness or tingling

13. Hematologic:
- □ Easy bruising or bleeding
- □ Blood in urine or stool

14. Psychiatric:
- □ Anxiety
- □ Depression
- □ Memory loss

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Consent Form For Skin Test And Oral Challenge

If you or your child has a clinical history suggesting allergy, we may do skin testing or perform an oral challenge to confirm or rule out an allergic process. Allergy skin testing by scratch or intradermal technique is usually done for certain "immediate" allergic conditions such as nasal allergies, asthma, other respiratory tract conditions, hives, skin swelling, or anaphylaxis.

What is a skin test?

A skin test is a simple method for detecting common allergens in patients suspected of having an allergy.

- Small amounts of allergens are applied to the skin with a disposable plastic prong (a scratch test)
- Or, small amounts of suspected allergens are injected a few cells deep into the skin (intradermal test).
- If an allergy is present, a wheal (a swollen reddened area) forms within about 15-20 minutes, which is observed and graded by the nurse or physician.

Patients should not take antihistamines for at least 2-7 days before the testing, depending on the drug. Otherwise the skin test may be masked by the antihistamine. Patients usually are tested for a panel of suspected allergens considered by the doctor to be appropriate for their needs. Skin testing is charged per number of tests performed, it is up to the patient and physician to decide on the number of skin tests that will be performed.

What is an oral challenge?

Oral challenge is a procedure where small doses of a drug or food are given orally to find out if a person is allergic to it. Oral challenge is used when:

- A previous reaction to a drug or food is uncertain
- Skin testing cannot be performed because of the nature of the antigen e.g., some drugs do not react on conventional skin testing
- The risk of taking the drug in incremental doses is small compared to the benefits of finding out what is causing the problem

During an oral challenge, we administer a dose of a drug or food below that which would potentially cause a serious reaction. If there is no reaction, we then proceed with incremental increases to full therapeutic dose. Although there is always the possibility of severe reactions, the risk of an oral challenge is low and most reactions are mild.

Can Reactions Occur?

In general, reactions are infrequent and may present as local itching or swelling to skin testing sites, or mouth itching and hives during an oral challenge. It is rare, but serious even life threatening reactions may occur. In that case, the patient must inform the doctor immediately if they have left the office or proceed to the emergency room.

I understand fully the above explanation and give South Bay Allergy and Asthma Group, Inc. staff permission to proceed with skin testing/oral challenge on _____ myself or (check for self or for minor child)

_____ my child _____, DOB: ____/____/_____
(Print Childs Last Name, First Name) (mm/ dd / yyyy)

Signature: _____ Date_____
(Signature of Patient or if minor of Parent/Legal Guardian)

Print Name _____ Relation to Patient: _____
(Name of Patient or if minor of Parent/Legal Guardian)

+

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Confidential Channel Communication Record

As required by the Health information Portability and Accountability Act of 1996, you have a right to request that communications concerning personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contract must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communication I may have made.

Please select:

☐ Home #: _____
- ☐ O.K. to leave detailed message
- ☐ Only leave call back number

☐ Cell #: _____
- ☐ O.K. to leave detailed message
- ☐ Only leave call back number

☐ Work #: _____
- ☐ O.K. to leave detailed message
- ☐ Only leave call back number

☐ Fax #: _____
- ☐ O.K. to leave detailed message
- ☐ Only leave call back number

What phone number is your preferred contact number? _____

Are there any other adults (>18 years old) who you authorize to receive information pertaining to your care? If so, please list below (along with best contact information):

_____ _____

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

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Acknowledgement of Appointment and Financial Policies

Appointment Policies: Late Policy, No Show Policy and Cancellation Policy

Out of respect for other patients, doctors, and staff, I understand that patients who are 15 minutes late or more will be asked to reschedule. I understand that if I cancel my appointment or attempt to reschedule my appointment without 24 hours advance notice, I may be charged $30.00 for an established patient appointment, or $50.00 for a new patient appointment. If I fail to show up for my appointment, I understand that I will be charged $30.00 for an established patient appointment, or $50.00 for a new patient appointment. Greater than 3 missed or late appointments during a calendar year may result in an inability to schedule further appointments.

Insurance Coverage Policy

I understand that it is **my responsibility** to verify my insurance policy coverage prior to an office visit. I also understand that it is **my responsibility** to provide staff accurate insurance information including a valid and updated insurance card.

Payment of known co-pays, deductibles, and co-insurance is due **at the time service is rendered**. All services not covered or approved by the insurance carrier remain my immediate responsibility.

I understand that it is **my responsibility** to notify South Bay Allergy & Asthma Group (SBAAG) of any change in my insurance coverage before the appointment date. If I fail to notify the office of a change in my insurance coverage, and claims are filed with incorrect insurance, I will be responsible for these charges.

I understand that if my insurance coverage is an HMO, EPO, or Managed Care type, that my insurance will only pay for services if prior authorization has been obtained for each visit. If I choose to be seen by the physician without the necessary authorization, I understand that I will be responsible for 100% of the charges.

If the physicians of SBAAG are not under contract with my insurance carrier, I understand that it is **my responsibility** to pay for that portion of services not covered by the plan policy.

Charges for Services

Actual costs of services are based on information discussed during the office visit, the severity of the condition, and the length of time spent by the physician, and other factors, thus an actual cost cannot be quoted. ***The patient responsibility for out-of-pocket costs are based on the contractual allowances per your insurance company, and are not determined by SBAAG.***
Skin testing for allergies is billed per test, and costs range between $8 and $15. Please discuss the number of tests being performed, if applicable, with your physician.

_____ _____

Signature (parent/guardian where applicable) Date

_____

Print Name