FLATIRON
ALLERGY & ASTHMA
CENTER

Welcome to Flatiron Allergy and Asthma Center.

We are a full service allergy, asthma & immunology clinic located in Louisville and are dedicated to providing the highest quality allergy & immunology care to our patients.

During your consultation, our physicians will obtain a detailed medical history, complete any allergy related testing (if indicated), and formulate an individualized treatment plan that best empowers you to feel confident about managing your allergic or immunologic disease.

In preparation for your consultation, we kindly request that you complete and bring with you the following information:

Demographics:

- ☐ Identification (Driver's License)
- ☐ Insurance Card
- ☐ Patient Registration Form
- ☐ Referral Letter (if required by insurance company)
- ☐ Co-pay/Payment (if required)
- ☐ Financial Policy Form
- ☐ HIPAA Acknowledgement Form

Clinical:

- ☐ Completed New Patient Form
- ☐ Allergy Skin Test Consent Form
- ☐ Review the Preparation for Allergy Skin Test Form
- ☐ Office Records from the Referring Physician (if applicable)
- ☐ List of Current Medications and Medication Allergies
- ☐ Recent Chest X Rays and CT Sinus Reports/Films (if applicable)

We are pleased that you have chosen us for your care and look forward to meeting you.

Sincerely,

The Staff of Flatiron Allergy and Asthma Center

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Today's Date _____ Pharmacy Name and Location _____
Patient's Name _____ Referring MD: _____
Date of Birth _____ Primary Care Provider: _____
It is ok to send you appointment reminders through email: Yes / No

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Reason for Visit:_____

Medical History (Please Circle)

Allergies
Anemia
Anxiety/Depression
Asthma
Autoimmune Disease
Bleeding Disorder/Clots
Cancer
Cataracts/Glaucoma
COPD/Emphysema
Diabetes
Eczema
GI Diseases
Heart Attack
Heart Disease
Heart Failure
High Blood Pressure
High Cholesterol
HIV/Hepatitis
Immunodeficiency
Kidney Disorder
Liver Disease
Lung Disease
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disease
Tuberculosis
Other_____
Other_____
Other_____

Medication Allergy/Reaction

_____

_____

_____

_____

Food Allergy/Reaction: _____

_____

Latex Allergy: Yes/No
Insect Adverse Reaction: Yes/No

Current Pregnancy: Yes/No

Surgical History (Please Circle)

Tonsillectomy/Adenoidectomy
Sinus or Polyp Surgery
Cardiac Surgery
Myringotomy Tubes(ear tubes)
Thyroid Surgery
Other_____
No previous surgery

Hospitalizations/ER visits
(Year of Visit/Reason)

_____

_____

_____

Social History

Marital Status: _____
Occupation_____
Smoking (current or prior) Yes/No
If so, How Much_____
How Long_____
Quit Date_____

Alcohol:
Rare____Social_____Daily___
Recreational Drug Use? Yes/No

If Patient is a child

Child Lives with: _____
Mother Full Name: _____
Father's Full Name: _____
Attends Daycare: Yes/No
Exposed to second hand smoke: Yes/No
Birth History: Vaginal/C-section
Birth Weight: _____ pounds

Immunization History:

Date/Year of Last Flu Shot: _____
Date/Year of Last Pneumonia Shot: _____
Pediatric Immunizations current: Yes/No

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Family Medical History (Parents, children, siblings only)
Allergy
Angioedema (swelling)
Asthma
Drug Allergy
Eczema
Food Allergy
Hives

Past Allergy Testing:
Never Tested Before
Prior Skin Test: **Yes/No** - Year: _____
Prior Allergy Shots: **Yes/No** - Year: _____
Currently on Allergy Shots: **Yes/No**

Date of Last Sinus CT Scan:_____
Date of Last Chest X-ray: _____
Date of Last Lung Test: _____

Environmental History
Where do you live? City/Country/Farm/Rural
Is your home: Single Family/Apartment/Condo/Townhome/Mobile Home
How long have you been in Colorado? _____ months/years
Heating: **(Circle One)** Gas/Electric/Baseboard/Forced Air/Fireplace (wood burning/gas/electric)
Cooling: Air Conditioner/Swamp Cooler/Window Fan
Flooring: Hardwood/Carpeting/Other: _____
Visible Mold or Water Damage? Yes/No **If Yes:** Mild/Moderate/Severe
Humidifier? Yes/No **Setting**: _____ **Air Purifier**: Yes/No
Do you have pets or animal exposure?
Type of animal(s):_____

Current Medications OR BRING A CURRENT LIST

Name	Dose	Frequency

Review of Systems: (Please Circle)
General/Constitutional: fatigue, fevers, headache, recent illness, weight gain, or weight loss
Eyes: contact lenses/glasses, disease or injury, itchy, pain, redness, watering, vision change
Ears/Nose/Throat/Neck: frequent sinus infections, hearing loss, itchy nose, nasal stuffiness, bleeding, pain, post-nasal drip, ringing of ears, runny nose, sneezing, snoring, masses in thyroid
Cardiovascular: chest pain, heart murmurs, or hypertension
Respiratory: cough, respiratory infections, shortness of breath, or wheezing
Gastrointestinal: abdominal pain, constipation, diarrhea, difficulty with swallowing, indigestion/heartburn, nausea, or vomiting
Genitourinary: frequency, infections, or urgency
Musculoskeletal: limitation of motion, pain, or swelling
Skin: dryness, eczema, hives, itching, or rash
Neurologic/Psychiatric: anxiety, depression, or seizures
Endocrine: diabetes, glandular problem/thyroid disorder, or intolerance to heat or cold
Hematologic: anemia, bleeding tendency, or previous transfusions and reactions
Allergic/Immunologic: frequent infections, reactions to: foods/insects/medications/vaccines

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PATIENT REGISTRATION FORM

Primary Care Physician _____ Referring Physician_____

First _____ Middle _____ Last _____

Preferred Name _____ Gender: Male Female Date of birth: _____ / _____ / _____

Social Security Number _____- _____ -_____ Employer _____

Marital status: Single Married Divorced Separated Widow(er) Other

RACE	**ETHNICITY**	**LANGUAGE**	**How did you hear about our office:**
American Indian	Hispanic	English	*CO Hometown Weekly*
Alaska Native	Latino	French	*CU Independent Google Daily Camera*
Black or African Amer.	Non Hispanic	German	*Yellow Book Dex Friend/Family*
Hispanic	Other	Japanese	*Yellowscene Women's Edition*
Multiracial	Refuse to Report	Mandarin	*Physician Insurance list Internet Search*
Other		Russian	
White		Spanish	

Address: _____ City _____ State _____ Zip _____

Phone Number ( )_____home ( )_____ cell ( )_____ work

Email: _____**Emergency Contact Number** ( )_____

PRIMARY INSURANCE: _____

Member ID _____ Group # _____ Copay _____

Insurance Subscriber Name: _____ Ins. Subscriber Date of Birth:_____

Relationship to subscriber: _____

SECONDARY INSURANCE: _____

Member ID _____ Group # _____ Copay _____

Insurance Subscriber Name: _____ Ins. Subscriber Date of Birth:_____

Relationship to subscriber: _____

RESPONSIBLE PARTY INFORMATION (If other than patient):

Name: _____ Date of birth: _____ Relationship to Patient: _____

Address: _____ City _____ State _____ Zip _____

Employer_____ Social Security # Responsible Party _____

I authorize the release of medical information necessary to process claims or obtain treatment. I authorize payment be made directly to the physician/clinic for services or supplies provided. I understand I am responsible for charges not paid by my insurance**. I understand I am responsible for obtaining referrals for services/supplies needed and I will be charged for those supplies/services received without a referral in place.**

_____ _____

PATIENT/PARENT SIGNATURE or LEGAL REPRESENTATIVE DATE

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FINANCIAL POLICY

Please understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients.

- We must emphasize that as a health care provider our relationship is with you, not your insurance company.
- Your insurance is a contract between you, your employer, and the insurance company.
- Contact your insurance company and/or your employer's human resource department with regards to your benefit questions.

PATIENT RESPONSIBILITIES:

- **Insurance Card(s):** We require a copy of your current insurance card upon every visit.
  We require your signature and a current card with every antigen order also.
- **Co-payments**: **Co-payments are due at time of service.**
- **Referrals**: If your insurance requires a referral, and you do not provide one at the time of service, you are responsible for any charges incurred.
- **Cancellations**: **For all appointments there is a 24 hour cancellation notice requirement.**
  There is a $25.00 charge for repeated late shows, late cancels or no shows.
  There is a $50.00 charge for the same on each new patient appointment missed.

If you have health insurance with which we participate:

- We will bill your insurance claim for you.
- We expect any required copayment at time of service.
- We expect payment of deductible and coinsurance to be paid in full after we have issued you a statement to be paid within 25 days unless prior payment arrangements have been made.

If you are uninsured or we do not participate with your insurance:

- We require you to sign an uninsured form.
- Payment for total charges is due in full on the day of your appointment unless you have signed a credit agreement with our office.

General:

- Payment of services is due by the person accompanying any minor child unless other arrangements have been made in advance.
- We will not bill two people for care. It is the responsibility of the accompanying adult to pay the amount due in full, and collect what is owed by others.
- Any unpaid balance over 30 days is subject to a 2% interest charge. A rebilling fee of $20.00 will also be added to unpaid balances over 30 days.

We accept payments in cash, check and credit (VISA, MASTERCARD, and DISCOVER). Post-dated checks are acceptable within 2 weeks and will be deposited on the check date. There will be a $50.00 charge for returned checks. Accounts over 90 days are subject to collection proceedings and ultimately dismissal for full collection accounts.

I take responsibility for researching the costs of my visit and any procedures related to the visit with my insurance company and understand that the costs not covered by the insurance company will be charged to me. I understand that I can discuss any visit related charges ahead of the visit with Flatiron Allergy & Asthma Center's billing department at 303-862-3303.

I have read and accept the terms of this financial policy.

Date: _____ Signature: _____

HOW WOULD YOU LIKE FOR US TO CONTACT YOU

For non-medical issues: *such as patient reminders, you can choose more than one*
□ Phone ( ) _____ □ U.S. Mail □ E-MAIL(non-encrypted) _____ □ Patient Web Portal

For medical issues: *such as test results, you can choose more than one*
□ Phone ( ) _____ □ OK □ Not OK to leave a message □ U.S. Mail

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I authorize the following individuals to inquire and receive verbal information regarding my care and sign a records release. (Actual release of medical records requires a separate form).
1. _____ Relationship _____ Date of Birth _____
2. _____ Relationship _____ Date of Birth _____

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Patient Consent Form for Allergy Skin Testing

Purpose:
Allergy skin testing is performed to assess for allergy antibodies to:

- environmental allergens (pollen, animal proteins, dust mite, mold, cockroach)
- food allergens
- insect venoms (honeybee, yellow jacket, yellow hornet, white faced hornet, paper wasp, fire ant)
- medications such as penicillin

Procedure:
Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a hive (swelling and redness). The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:

Prick:
In prick allergy skin testing, a sharp plastic lancet is passed through the allergenic extract or control solution, the skin on the back or forearm is lifted and a small break in the epidermis is created through which the extract or solution penetrates. If an allergenic sensitivity is present, a hive/welt like reaction develops in the area of prick.

Intradermal:
Intradermal allergy skin testing is most commonly completed adjunctively to negative prick testing in evaluation of environmental, venom, and drug allergy. In intradermal skin testing, a small needle is used to inject the allergenic extract or control solution into a deeper layer of skin, called the dermis, on the arm. If an allergenic sensitivity is present, a hive/welt like reaction develops in the area of intradermal application.

Interpretation:
Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so.

Risks:
Skin testing will be administered at this medical facility with a medical physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reaction to the allergy testing and beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.

Alternatives:
Allergy skin testing is considered superior and less expensive than specific IgE blood tests in the diagnosis of allergy.

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours for which special allergens may be prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours notice. Due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized.

Insurance:
Unfortunately, we cannot know each patient's specific insurance plan, deductibles, co-insurance, etc. If you have questions or concerns about the potential cost of allergy skin testing, please ask the front desk or your insurance company prior to having the procedure performed. If a referral is required by your insurance company, it is your responsibility to obtain same prior to your procedure. If your insurance company denies skin testing charges for any reason (non-medical necessity, referral required, etc.), you will be responsible for the incurred charges.

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient_____ Date signed_____

Parent or legal guardian*_____ Date signed_____
*as parent or legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.

Witness _____ Date signed_____

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Preparation for Allergy Skin Testing

As part of your allergy consultation, allergy skin testing maybe indicated. The interpretation of these tests can be adversely affected by use of antihistamine medications and those medications with antihistaminic activity.

To best ensure a high quality allergy skin test, it is necessary to avoid the following medications as listed below:

- ✓ Please discontinue the following medications, as well as any over-the counter allergy & sinus medications for at least 5 days prior to your visit:

  - Alavert (Loratidine)
  - Alaway (Ketotifen)
  - Allegra (Fexofenadine)
  - Astepro (Azelastine)
  - Azelastine
  - Atarax (Hydroxyzine)
  - Chlortrimeton (Chlorpheniramine)
  - Clarinex (Desloratidine)
  - Claritin (Loratidine)
  - Dimetapp (Brompheniramine)
  - Dymista (Azelastine + Fluticasone)
  - Nyquil (Doxylamine)
  - Optivar (Azelastine)
  - Patanase (Olopatadine)
  - Tavist (Clemastine)
  - Vistaril (Hydroxyzine)
  - Xyzal (Levocetirizine)
  - Zaditor (Ketotifen)
  - Zyrtec (Cetirizine)
  - Zyrtec Itchy Eyes (Ketotifen)

- ✓ Please discontinue the following medications for at least 2 days prior to your visit:

  - Axid (Nizatidine)
  - Benadryl (Diphenhydramine)
  - Pepcid (Famotidine)
  - Tagamet (Cimetidine)
  - Zantac (Ranitidine)

The application of topical steroids to the forearms and back should be avoided for at least 2-3 weeks prior to your visit.

Medications such as benzodiazepines, tricyclic antidepressants, as well as other antidepressants may suppress responses to skin testing. If you are on these medications, please contact the prescribing physician and inquire if these medications can be safely stopped.

You can continue to take inhaled, nasal, and oral steroids without interfering with allergy skin testing.

Allergy skin tests are generally safe, but rarely life-threatening allergic reactions may occur. Symptoms of such reactions can include hives, swelling, breathing troubles, and low blood pressure.

Due to this risk, it is important that you let us know if you have a history of anaphylaxis, unstable asthma, are pregnant, and/or are on beta blockers, ACE inhibitors, or MAO inhibitors. Having these conditions, being pregnant, or being on these medications may make a rare allergic reaction to skin testing more severe and/or more difficult to treat.

Acknowledgement of Receipt of Notice of Privacy Practices

Flatiron Allergy & Asthma Center

Principal Location: 90 Health Park Dr. Suite 170. Louisville, CO 80027

Amanda Sanderson Tel: 303-862-3303 (Office)

I hereby acknowledge that I received 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 a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

_____

I Authorize Flatiron Allergy & Asthma Center to obtain my medication history thru their pharmacy clearinghouse. Please circle. (This improves accuracy of information)

Yes **No**

I authorize the following persons to consent for needed treatment in my absence for _____ (Minors only.)

Name:	DOB:
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient or Guardian: _____

Print Name: _____

Date: _____ Telephone: _____