# ALLERGY AND ASTHMA HEALTHCARE

Maria D. Sabio, MD

Ernesto Ruiz-Huidobro, MD

# **Patient Information**

Patient Name:			Date of Birth:/
Last	First	M	Marital States
SSN #://			Marital Status:
			Phone: Home
Street			WorkCell
City S	tate Zip	Code	
Insurance Policy Holder (MUST &	e 18 or older)*		Birthdate / /
	Name		
SSN://	_ Gende	er:	Marital Status:
Phone:	Address:		
	(if different fr	om above)	
Work Phone (if not given above)			
Employer:Name			
Name	Ad	Idress	
Primary Care Doctor:		Pho	ne/Fax: other:
Who referred you to us? Doctor_		OR	other:
Primary Insurance:		Policy Hold	er:
Secondary Insurance:		Policy Holde	er:
I authorize this office to release m	y health informat	tion to my Emer	gency contact(s):
Name:	Relation	snip:	Phone: Phone:
ivanic.	Notation:	siip	I none
I have provided true and accurate	information abov	e. I realize that	I will be responsible in full for any service
not covered by my insurance carr	er(s). I realize th	at I am responsi	ble for any charges incurred due to incorrect
information I have provided.			
		/	1
Responsible Party Signature		Relationsl	nip Date

# ALLERGY AND ASTHMA HEALTHCARE

Maria D. Sabio, MD

Responsible Party Signature

Ernesto Ruiz-Huidobro, MD

### Parent Information for Patients under Parent's Policy

\*Health Information is authorized to be release to all parties listed below\* Father Name: Date of Birth: / / First SSN: Marital Status: [ ] married [ ] single [ ] divorced [ ] widowed Address: Phone: Home City State Occupation: Work Phone Employer: \_\_\_ Address Mother Name: Date of Birth: / / Last First M Marital Status: [ ] married [ ] single [ ] divorced [ ] widowed SSN: □ Check if address information is same as above Address: Phone: Home Street Cell \_\_\_\_\_ City State Zip Occupation: \_\_ Work Phone Employer: \_\_ Address Other Guardian Name: \_\_ Date of Birth: SSN: / Marital Status: [ ] married [ ] single [ ] divorced [ ] widowed □ Check if address information is same as above Address: Phone: Home Cell City State Zip Occupation: Work Phone Employer: Name Address I have provided true and accurate information above.

#### **ALLERGY and ASTHMA HEALTHCARE**

Maria D. Sabio MD, PC

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you anytime. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, financial agreement or your financial responsibility.

- 1. APPOINTMENTS-This practice requires at least 24 hours advanced notice for appointment cancellations. A \$30.00 fee will be charged to the patient's account if a patient fails to give advanced notice and does not show for their scheduled appointment.
- 2. **REFERRALS**-If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain a referral prior to your appointment. Referrals must be received in our office by the time of your visit. If no referral is received by the time of service, it is your responsible for the charges that day's services.
- 3. CO-PAYMENTS-By contract with your insurance carrier, we MUST collect your carrier designated copay. This payment is expected at the time of service. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of \$10.00 may be added to your account.
- 4. ADMINISTRATIVE FEES are charged to the following- FMLA AND WORKERS' COMPENSATION: \$35.00, HEALTH LETTERS BY DOCTORS AND NON-AAH HEALTH FORMS: \$3.00 each, DETAILED BILLING STATEMENTS: \$1.00 per page, MEDICAL RECORDS: Fees according to MO Dept of Health and Senior Service, REPLACEMENT SHOT CARDS: \$2.00 each. We require 3-business days for processing of these forms. Patient must be current on check-up appointments.
- 5. SELF-PAY PATIENTS-Payment is expected at the time of service.
- 6. DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS-The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Maria D. Sabio, MD, PC. will not be involved with separation or divorce disputes.
- 7. **INSUFFICIENT FUND CHECKS-**a \$25.00 fee will be charged to patient's account for checks returned due to non sufficient funds.
- 8. BALANCE ON ACCOUNT-Accounts with balances for 31+ days or more will be subject to a 2% late fee.
- 9. NON PAYMENT-Accounts with an outstanding balance for 90+ days will be charged collections fees and forwarded to a third party for collections. All collections fees are the patient's responsibility. NO ADDITIONAL CONTACT WILL BE MADE BY OUR OFFICE AT THAT POINT.
- 10. PRIVACY POLICY- I have received and had time to review the Notice of Privacy Practices.

ALL FEES STATED IN THIS FINANCIAL AGREEMENT ARE NOT BILLED TO INSURANCE. FEES ARE PATIENT'S FINANCIAL RESPONSIBILITY.

<u>I have read and fully understand e</u>	ach item of the p	<u>practice's patient financial agreem</u>	ent and agree to be bound by it's
<u>terms. I also understand and agre</u>	e that such terms	mav be periodically amended by i	the practice.
Print Patient Name	Pat	ient Signature	Date
WHE.			
Signature of Person Authorized	l to Consent	Relationship to Patient	Patient's Date of Birth

## **ALLERGY AND ASTHMA HEALTHCARE**

## Maria D. Sabio, MD Ernesto Ruiz-Huidobro, MD, FAAAAI

(Your name/child's name)	(Nickname?)	
(Age)		
(Date of visit to our office)		
Name of parent or guardian if applies)		

Welcome to Allergy and Asthma Healthcare! It is our obligation to provide for you the best care we can offer for your allergy and asthma needs. By using the following questionnaire, please describe your symptoms to us in as detailed a manner as possible so we will gain a full understanding of what you are experiencing. Please be careful to relate all answers to your own experience, not to previous advice on allergy or skin tests. Answer only the questions that apply to you. *All information will be considered confidential* 

PLEASE NOTE THAT THESE PAGES WILL BECOME A PART OF YOUR OFFICIAL RECORD AT OUR OFFICE.

C.C: What is the main reason for your visit today? IF YOU HAVE EXPERIENCED A SEVERE ALLERGIC REACTION,

# PROCEED TO PAGE 5 AND COMPLETE THOSE QUESTIONS THAT APPLY.

	DUCTUR S NUTES
Please tell us what symptoms you are experiencing. Check all that apply.	
□ Cough _	
Frequency	
□ Daily	
□ Weekly	
□ Monthly	
□ Rarely	
Does the cough affect your sleep?	
□ Yes How many times in 1 week? or days a week	
□ No	
Are your activities limited by the cough?	
□ Talking	
□ Daily routine activities?	
□ Exercise	
Other concerns about the cough you would like to discuss	
□ Wheezing	
Frequency	
□ Daily	
□ Weekly	
□ Monthly	
□ Rarely	
Does the wheeze awaken you from sleep?	
□ Yes How many times in 1 week? or days a week	
Around what time?o'clock in the AM	
o'clock in the PM	
□ No	
Are your activities limited by wheezing?	
□ Talking	
□ Daily routine activities?	
□ Exercise	
□ Shortness of Breath ( a feeling of being short-winded)	
Frequency	
□ Daily	
□ Weekly	
□ Monthly	
□ Rarely	
Do you wake up from sleep with difficulty breathing?	
□ Yes How many times in 1 week? or days a week	
Around what time?o'clock in the AM	
o'clock in the PM	
□ No	
<u> </u>	
Are your activities limited by breathing difficulty?	
□ Talking	
□ Daily routine activities?	
□ Exercise	
What helps you breathe better?	

<b>c.</b> Please tell us what symptoms you are experiencing. Check all that apply	DOCTOR'S NOTES
□ Phiegm/Mucous	
Color	
□ Clear	
□ White	
□ Yellow/Green	
□ Bloody	
Consistency	
□ Watery	
□ Thick	
Are you constantly having to clear your throat?	
□Yes	
□ No	
Are you frequently coughing or gagging?	
□ Yes	
□ No	
□ Nasal/Sinus Symptoms	
Sneezing	
Itching	
Post Nasal Drip	
Runny nose (What makes your nose run?)	
□ Cold weather	
□ Eating	
□ Certain smells	
Nose bleeding	
STUFFINESS/NASAL CONGESTION	
□ Everyday	
□ In the morning only	
□ Any time of the day	
□ Around certain triggers	
Please rate severity: (circle)	
1 2 3 4 5 6 7 8 9 10	
(least) (worse)	
Does the congestion affect your ability to sleep?	
□ Yes	
□ No	
Does the congestion affect your ability to smell or taste?	
□ Yes	
□ No	
HEADACHES	
Where are your headaches located?	
□ Forehead	
□ Temples	
□ Cheekbones	
□ Other:	
SINUS INFECTIONS	
□ 1 - 2 times a year	
□ 3 - 5 times a year	
□ > 6 times a year	
Usual duration of antibiotic courses	
□ 7 - 10 days	
□ 30 days or more	
Any X-RAYS or evaluation by an Ear, Nose and Throat specialist?	
□ Yes When:Where:	
□ No	
Have you had sinus surgery in the past:	
□ Yes When: Where:	

C.C. Please tell us what symptoms you are experiencing. Check all that apply	DOCTOR'S NOTES
EYE SYMPTOMS	
□ Itching	
□ Burning	
□ Redness	
□ Redness	
□ Swelling	
□ Tearing	
□ Mucous	
□ Crusting	
THROAT/ROOF OF MOUTH SYMPTOMS	
□ Itching	
□ Soreness	
☐ Hoarseness / loss of voice	
□ Frequent bouts of throat infections	
EAR SYMPTOMS	
□ Itching	
□ Popping	
□ Pain	
□ Stuffiness	
□ Frequent ear infections	
□ Previous ear tube placement	
Other history:	
SKIN SYMPTOMS	
LOCATION OF INVOLVEMENT	
□ Scalp	
□ Face	
□ Neck	
□ Arms	
□ Hands	
□ Legs	
□ Feet	
□ Chest	
□ Abdomen	
□ Back	
SYMPTOMS	
□ Itching	
□ Swelling	·
□ Hives	
Size?	
Pinpoint	· · · · · · · · · · · · · · · · · · ·
Coin sized	
Size of an orange	
Massive	
Duration?	
Minutes	
Less than 24 hours	
Are there any residual marks?	
Redness	
Bruising	
□ Eczema	
Moisturizer:	
Soap:	
Daily Routine:	
	B

ease tell us more abou		-		L	DOCTOR'S NOTES
(Please describe the	e <u>PATTER</u>	RNS of thos	e you listed)		
ng have you been bo	sthered by	the above	montioned even	tomo?	
ng nave you been bo	Milered by	tite above	mentioned Sym	roms, F	
	Days			-	
	Weeks			<u> </u>	
	— Months			<u> </u>	
	Years			T	
	<del></del>				
When are your syn	nptoms at	their wors	e?	<u> </u>	
□ Year Round					
□ Winter (circle)	Dec	Jan	Feb		
□ Spring (circle)	Mar	Apr	May		
□ Summer <i>(circle)</i>	Jun	Jul	Aug		
□ Fall (circle)	Sept	Oct	Nov		
a of the items below			f		
h of the items below	v trigger a	worsening	or your sympto	ms?	
Irritants				L	
□ Tobacco smoke				_	
□ Perfume				1_	
□ Powder					
□ Detergents				_	
□ Aerosols					
□ Motor fumes					
□ Hair spray				<u></u>	
□ Chemical Fumes				_	
Weather Change	es				
□ Humidity					
□ Cold temperatures					
□ Pollution (i.e. "bad				L	
□ Changes in tempe	erature			L_	
□ Rainy days				L	
□ Dry / windy weath	er			L.	
Animals					
□ Dog					
□ Cat				_	
□ Birds					
□ Horses					
□ hamsters / guinea	pigs / rabb	oits		_	
□ Mice/rats				L	
□ Other:					
Infections				_	
□ Colds / Flu					
☐ Bronchitis / pneum				L	
Contacts (circle to					
□ poison ivy / cut gra			/ Christmas trees		
□ dust / wool blanke	ts / feather	s / rugs			
□ furs / jewelry					
□ soaps / shampoos	/ lotions				
Miscellaneous					
□ Laughing					
□ Fatigue					
□ Traveling					
□ Emotions					
□ Exercise or other s	strenuous :	activities			
Other:				1	

## If you have experienced a severe allergic reaction, please answer the following questions to help us understand the course of events. **BEE STING / DRUG ALLERGIES** Date of reaction: Previous stings / exposure to suspected drug :\_\_\_\_\_ □ Yes Any reaction at that time? п No Symptoms: (indicate the order of occurrence by number) Flushing / Redness Hives Swelling at sting / injection site Swelling of other areas Throat closure / inability to talk or swallow Coughing Difficulty breathing Lightheaded Unconsciousness Other: How soon after the sting / exposure did the symptoms start? □ 15 - 30 minutes □ Hours □ Days □ Weeks Emergency Room / Emergency Medical services / Hospitalization What was done: What Medicines did you take at home after discharge? FOOD ALLERGIES: Date of reaction: Suspecte food(s): Reaction: How soon after eating did the symptoms start? □ 15 - 30 minutes . Hours □ Days Emergency Room / Emergency Medical services / Hospitalization Where: What was done:

What Medicines did you take at home after discharge?

SEVERE ALLERGIC REACTIONS: (If applies)

**DOCTOR'S NOTES** 

PAST MEDICAL / SURGICAL HISTORY	
	DOCTOR'S NOTES
Please list any current medical conditions for which you see	
a doctor ot for which you take medications on a regular basis:	
•	
If Pregnant:	
Due Date:	
Name of Obstetrician: Ph.#	
Previous Surgeries:	
When:	
When:	
When:	
CURRENT MEDICATIONS AND DOSAGES	
	:
L.,	
0.455 7.15 0.01.15 0.01.	
OVER THE COUNTER MEDICATIONS/VITAMINS/ ETC.	
DRUG ALLERGIES (LIST REACTIONS)	
(2.01.1.2.07)	
W-1-1	
IMMUNIZATIONS: UP TO DATE? (circle) Yes No	
PAST ALLERGY/ASTHMA TREATMENT HISTORY	
Allergy Testing	
□ Skin test When:	
VA /	
Where:	
□ Blood test When:	
Where:	
To what were you found to be allergic when you were tested?	
Allergy injections:	
□ Yes How long did you receive them?	
□ No	
D 140	
O'	
Sinus X-rays: Dates:	
Asthma Dates:	
ER visits: Dates:	
Recent chest x-rays: Dates:	**************************************
Yearly Flu Shots?   NO  YES Date of last Flu shot?:	
What medications have you tried in the past to relieve your	
allergy or asthma symptoms?	
Name Effective ?	
Yes No	
Yes No	
Yes No	

ADDITIONAL HISTORY FOR CHILDREN BEING EVALUATED	DOCTOR'S NOTES
(Please answer the following in addition, if your child is being eva	luated
today; otherwise proceed to the next pages)	
Durchiana in Burana a	
Problems in Pregnancy?	
□ Yes (please list)	
□ No	
Drobleme during labor and delivery 0	
Problems during labor and delivery?  □ Yes (please list)	
□ Yes (please list)	
□ No	_
LINO	
Prematurity:	
Weeks gestation	
NICU?	
□ Yes How long?	
□ No	
Required Oxygen?	
□ Yes How long?	
□ No	
Feeding History	
Breast Fed:	
□ Yes How long?	
□ No	
Formula Fed:	
□ Yes How long?	
□ No	
Any problems with feeding?	
□ Projectile vomiting	
□ Spitting up excessively	
□ Colic	
A 11 20 4 10 4	
Any problems with transition to:	
□ Cow's milk (list)	
□ Solid foods (list)	
Has your child had problems currently or in the past with:	
□ Croup	
□ Bronchitis	
□ Bronchiolitis	
□ Pneumonia	
□ Ear infections Tubes? (circle) Yes	No
□ Sinus infections	
□ Throat infections	
□ Chicken pox	
□ Measles / mumps	
□ Flu	
Other:	

REVIEW	OF SYSTEMS		
	coblems that may be bothering you) Circle all that app	oly.	DOCTOR'S NOTES
GENERA	L: fever, weight loss / gain, muscle aches		
ENT:	voice problems, lumps in the neck, throat clearing		
RESPIRA	ATORY: emphysema, COPD, lung edema, blood i		
CARDIO	VASCULAR chest pain, high blood pressure, heart fail	ure	
ABDOME	N: pain, nausea, vomiting, cramps, diarrhea,		
	blood in stools, heartburn, reflux, regurgitation		
NEUROL	OGICAL: headaches, migraines, seizures		
OTHER:	The state of the s		
		-	
		-	
•		-	
SOCIAL	HISTORY:		
	Occupation:		
	Occupation.	<b>-</b>	
	I anoth of time at astablishment.	·· 414 -	
	Length of time at establishment:	months	
	Ohaninal avanage (if and).	_years	
	Chemical exposures (if any):		
		-	
	Number of missed days due to illness in one year:		
	Grade in school (if student):	_	
		_	
	Number of missed days due to illness in one year:		
	Childcare arrangements (for infants/toddlers/prescho	oolers)	
	□ Daycare How many times a week?	<u> </u>	
	□ Home How many kids in it?		
	Smoke Exposure		
	□ Self Packs per day Number of years	?	
	□ Passive tobacco exposure		
	□ Home		
	□ Work		
FAMILY H	HSTORY:		
	Asthma? (Please list affected blood-related family mem	nhers)	
	(	10010)	
-		•	
-		•	
-			
	Allergy? (Please list affected blood-related family mem	hara\	
•	Anergy: (Floase list affected blood-related family mem	ibeis)	
-			
-			
-			
_			
,	OTHER? (Please list affected blood-related family mem	ibers)	
·			
_			

Page 9

ENVIRONMENTAL HISTORY	DOCTODIO NOTTO
Please provide a description of your home environment.	DOCTOR'S NOTES
For children who has dual residencies, please indicate which home is being	
described here, although it would be best to describe both places if possible.	
described here, difficult it would be best to describe both places it possible.	
Type of domain: How old?	
How long have you lived there	
□ Apartment	
□ Duplex	
□ Townhouse	
□ Single family home	
□ Farmhouse	
□ Mobile home	
Location of house:	
□ City	···
□ Suburbs	
□ Rural	
i Kulai	
Whithin a few mile radius from home is there:	
□ Lake, pond, creek, river	
□ Factory	
□ Farm field	
Inside the home; do you have:	
□ Fireplace How often it is used?	
□ Wood-burning stove How often it is used?	
□ Furnace filter How often is it changed?	
□ Indoor plants How many? Which rooms	
DUSTY?	
□ Basement □ Musty	
(or crawl space;)   Dry	
□ Dehumidifier on	
□ Finished	
□ Unfinished	
□ Tobacco smoke exposure	
Do you have pets: (circle all that apply)	
□ Cat(s) # indoor outdoor sleeps in bedroom	
How long has the pet been with the family?years	
□ Dog(s) # indoor outdoor sleeps in bedroom	
How long has the pet been with the family?	
□ Hamster / guinea pig / rabbit / mice #	
□ Other:	
our bedroom (or child's bedroom, if child is the patient)	
Flooring	
□ Carpet	
□ Hardwood floor	
□ Linoleum	
D. 1.1.	
Bedding	
□ Mattress/box spring	
□ Waterbed	
□ Other mattress type:	
□ Pillows: (circle) feather foam polyester-filled	
Allergy-proofing	

□ In room filter
□ Dust mite encasing