

PATIENT INFORMATION SHEET

Please Circle One:	Mrs.	Ms.	Miss	Mr.	Child	Single	Married	Divorced	Widowed
Patient Name: _____									
Date of Birth	Age			Male			Female		
Home Address					City,St,Zip				
Home Phone					Cell #				
Race	☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian-Alaskan Native ☐ Other Race								
Ethnicity	☐ Hispanic Latino ☐ Non-Hispanic or Latino				Preferred Language: ☐ English ☐ Other:				
EMAIL	Driver's Lic. #								

Preferred Means of Communication(Please Check One): ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Mail ☐ Any

REFERRED BY _____

FAMILY PHYSICIAN	PHYSICIAN PHONE #
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IF PATIENT IS A MINOR:

Father's Name: _____	Mother's Name: _____
Birthday _____	Birthday _____
Occupation _____	Occupation _____
Employer _____	Employer _____
Street _____	Street _____
City,St,Zip Code _____	City,St,Zip code _____
Phone # _____	Phone # _____

EMERGENCY CONTACT	RELATIONSHIP	PHONE #
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PRIMARY INSURANCE:	circle:	EPO / HMO / PPO / POS
Primary Insured Name _____	D.O.B.	SS# _____
Insured's Employer _____	Occupation _____	
Insurance Company Name _____	DL # _____	
Insurance Address _____	Effective Date _____	
Insurance Ph. # _____	Relationship to Subscriber _____	
ID # on Card _____	Group # _____	

SECONDARY INSURANCE:	circle:	EPO / HMO / PPO / POS
Primary Insured Name _____	D.O.B.	SS# _____
Insured's Employer _____	Occupation _____	
Insurance Company Name _____	DL # _____	
Insurance Address _____	Effective Date _____	
Insurance Ph. # _____	Effective Date _____	
ID # on Card _____	Group # _____	

*** **PLEASE READ** ***

INSURANCE INFORMATION: I acknowledge that the physicians of Allergy and Asthma Assoc. may or may not be a part of the provider network for my insurance company and that it is my responsibility to verify that the providers are participating in my network. Please give your card(s) to the receptionist so we may keep a copy on file. All professional services rendered are charged to the patient/guardian. The patient is responsible for all fees regardless of insurance coverage. I hereby authorize Allergy and Asthma Assoc. to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and that it is my responsibility to ask for an estimation of the costs of any tests being recommended/ordered prior to them being performed. My signature below indicates that I have read and agree to these said statements.

Signature: _____ Date: _____



**Allergy & Asthma
Associates
of Southern California**

Leading-edge, personalized care you can trust

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William E. Berger, M.D. Warner W. Carr, M.D. Mark S. Sugar, M.D. Christina D. Schwindt, M.D. Faith R. Huang, M.D.
Diplomates of the American Board of Allergy and Immunology

PATIENT NAME: _____ TODAY'S DATE: _____
DATE OF BIRTH: _____ SEX: M F AGE: _____
EMAIL ADDRESS: _____
REFERRED BY: _____ PCP: _____

INSTRUCTIONS FOR COMPLETING HEALTH QUESTIONNAIRE: If you are unable to complete this form online or prefer to fill out a hard copy, please print and complete this document, bringing it with you when you arrive for your first appointment. This form is designed to help find the cause of your problem and is an essential part of your evaluation, aiding in the proper selection of tests and treatments, and allowing us to spend more time focusing on your important problems. When possible, please provide a start and stop date for all medical conditions as well as provide a check box in the Med Taken box if you are currently taking medication for that condition. If you have a condition that is not listed please add it in the OTHER section.

****PLEASE NOTE:** No antihistamines, such as Claritin, Allegra, Zyrtec, or Benadryl for at least 72 hours before your appointment, as they interfere with allergy testing. Asthma medications are allowed if needed for wheezing and coughing. If you are unsure of any medication you are presently taking, please call our office for instructions. **

CHIEF COMPLAINT: (The main reason you are here)

HISTORY OF PRESENT ILLNESS (Please provide a brief description of your current condition)

Please List All Current Medications

Dosages

PATIENT NAME: _____ DOB: _____

Please indicate if you have **EVER** been diagnosed with any of the medical conditions listed below

Allergies ☐ Hayfever or Allergic Rhinitis (Stuffy, Runny, Itchy Nose, Sneezing) Symptoms Worse: ☐ Indoors ☐ Outdoors ☐ Both ☐ Allergic Conjunctivitis (Red, Itchy Eyes) ☐ Food Allergy List Each Food and Reaction: _____ _____ _____ ☐ Stinging Insect Allergy (Bee, Wasp, Hornet, Etc.)? _____ ☐ Allergy Tested Before? Date: _____ ☐ Received Allergy Injections? Date: _____ Eyes, Ears, Nose & Throat ☐ Sinus Infections ☐ Nasal Polyps ☐ Bloody Nose ☐ Tubes in Ears ☐ Ear Infections ☐ Hearing Loss ☐ Cataracts ☐ Glaucoma Lungs/Pulmonary ☐ Asthma If yes: ☐ Have you ever used oral steroids for Asthma/COPD? Date: _____ ☐ Have you ever been hospitalized Asthma/COPD? Date: _____ ☐ # of ER visits in the past year for Asthma/COPD # _____ ☐ How many times per week do you use your rescue medication? #: _____ ☐ Pneumonia Date: _____ ☐ Pulmonary Embolism Date: _____ ☐ Smoking Packs/Day _____ Yrs of Smoking: _____ Date Quit: _____ Skin/Dermatologic ☐ Eczema ☐ Hives Other Rash: _____ Endocrine ☐ Diabetes ☐ Thyroid Disease ☐ Other Endocrine Problems: _____	Heart/Cardiovascular ☐ High Blood Pressure ☐ Heart Attack ☐ Angina or Chest Pain ☐ High Cholesterol ☐ Heart Murmur ☐ Arrhythmias Digestive/Gastrointestinal ☐ Ulcer ☐ Acid Reflux or Heartburn ☐ Nausea or Vomitting ☐ Irritable Bowel ☐ Diarrhea ☐ Hepatitis Genitourinary/Gynecological ☐ Urinary Tract Infections ☐ Enlarged Prostate ☐ Menopause ☐ Genital Herpes ☐ Hysterectomy Rheumatologic ☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Other: _____ Neurologic ☐ Migraine Headaches ☐ Stroke ☐ Other Neurologic Disorder: _____ ☐ Sinus Headaches ☐ Seizures Psychiatric ☐ Depression ☐ Bipolar Disorder ☐ Other Psychiatric Disorder: _____ ☐ Anxiety ☐ ADD/ADHD Other Chronic Medical Conditions: _____ _____ _____ _____ _____ _____
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PATIENT NAME: _____ DOB: _____

Cancer (Please specify type): 	Environmental ☐ Carpet ☐ Smokers in the home ☐ Pets (If yes, select type) ☐ Cat ☐ Dog ☐ Other: _____
Surgical Procedures (List any previous surgeries and dates) 	Review of Symstems Please indicate any Current problems in the following areas: General ☐ Chills ☐ Fever ☐ Weightloss ☐ Fatigue Eyes ☐ Change in vision ☐ Itchy ☐ Red ☐ Watery Ears ☐ Ear Infection ☐ Decreased Hearing ☐ Ear Popping Nose ☐ Congestion ☐ Runny Nose ☐ Sneezing ☐ Itchy Nose ☐ Sinus Infection ☐ Post Nasal Drip ☐ Seasonal Allergies Throat ☐ Sore Throat ☐ Change In Voice Respiratory ☐ Shortness of Breath ☐ Cough ☐ Pain With Breathing ☐ Wheezing ☐ Problems with exercise Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ Arrythmias ☐ Leg Swelling Gastrointestinal ☐ Abdominal Pain ☐ GERD or Acid Reflux ☐ Diarrhea ☐ Food Allergy Reproductive ☐ Penile Discharge ☐ Vaginal Discharge ☐ Breast Pain ☐ Breast Lump ☐ Sexual Dysfunction Skin ☐ Hives ☐ Red Rash ☐ Itchy Rash ☐ Contact Allergy
Previous Evaluation ☐ Allergy Tested Before? Date: _____ ☐ Received Allergy Injections? Date: _____ ☐ Pulmonary Function Testing? Date: _____ Medications that made your symptoms better: _____ Medications tried but did not help: _____	
Family History (Check all that apply & the relationship) ☐ Hayfever? Relationship: _____ ☐ Asthma? Relationship: _____ ☐ Sinus Problems? Relationship: _____ ☐ Eczema? Relationship: _____ ☐ Bronchitis? Relationship: _____ ☐ Emphysema? Relationship: _____ ☐ Cystic Fibrosis? Relationship: _____ ☐ Diabetes? Relationship: _____ ☐ Heart Disease? Relationship: _____	
Social History ☐ Married ☐ Single ☐ Widow/Widower School: _____ Grade: _____ Occupation: _____ Do you smoke? ☐ Yes ☐ No ☐ Quit Packs Per Day? _____ How many years? _____ Do you drink alchohol? ☐ Yes ☐ No ☐ Quit How many drinks per week? _____ Do you drink caffeine (Coffee/Tea/Caffeinated Soda)? ☐ Yes ☐ No Type: _____ Cups/Day: _____ Do you use any illicit drugs? ☐ Yes ☐ No ☐ Quit Type: _____	

PATIENT NAME: _____ DOB: _____

Review of Systems (continued)

Neurologic

- ☐ Dizziness ☐ Headache ☐ Numbness
☐ Vertigo/Room Spinning

Musculoskeletal

- ☐ Back Pain ☐ Joint Pain ☐ Muscle Aches

Psychiatric

- ☐ Anxiety ☐ Depression ☐ Increased Stress

Other (Please Describe):

PLEASE NOTE: ALL INFORMATION SUBMITTED ON THIS FORM IS CONSIDERED SECURE HEALTHCARE INFORMATION AND IS HELD IN THE STRICTEST CONFIDENCE, PROTECTING YOUR RIGHTS TO PRIVACY.

QUESTIONNAIRE COMPLETED BY: _____

RELATIONSHIP TO PATIENT: _____

DATE COMPLETED: _____

FOR OFFICE USE ONLY

This history form has been reviewed and discussed in detail with the patient.

Physician Signature

Date

**“NOTICE TO CONSUMERS: MEDICAL DOCTORS ARE
LICENSED AND REGULATED BY THE MEDICAL BOARDS
OF CALIFORNIA, (800) 633-2322, WWW.MBC.CA.GOV”**

William E. Berger, MD, CA Med Lic# C35918,
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Allergy & Asthma Associates of Southern California

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**“NOTICE TO CONSUMERS: PHYSICIAN ASSISTANTS ARE
LICENSED AND REGULATED BY THE PHYSICIAN
ASSISTANTS COMMITTEE. (916) 561-8780,
WWW.PAC.CA.GOV”**

April N. Showalter, PA-C, CA Lic#21000
Sumit K. Singh, PA-C, CA Lic#23282

Patient Signature

Date

Printed Patient Name

ALLERGY & ASTHMA ASSOCIATES

FINANCIAL POLICY

We appreciate the confidence that you have expressed in selecting us as your physicians, and we are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

Payment in full is required at the time of service for:

1. Patients without insurance (self-pay)
2. Patients who are not covered by one of our contracted insurance plans.
3. Patients who do not provide us with contracted insurance information
4. Patients with outstanding balances owed for co-pays, and deductibles as well as any non-covered services.

ALL COPAYS ARE DUE AT THE TIME OF SERVICE

We accept cash, personal checks, Visa & MasterCard

For Medicare & contracted insurance plans, we will bill all services at no charge as per the requirements of the insurance contract.

All returned checks may be subject to a \$20.00 service charge. You may be responsible for other costs of collection as permitted by law.

If the patient is a minor (17 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.

Referrals

It is your responsibility to obtain any required referrals for treatment at, or prior to, the time of your visit. Patients seen or treated in our office, without prior authorization from their HMO group, are responsible for the full charge of the visit. If you need to use a specific lab or x-ray facility, you must notify the nurse before the service is rendered.

Services rendered by this office that are not a covered benefit of your insurance policy will be patient responsibility.

Our office staff will assist you in dealing with your insurance carrier, but it is your responsibility to know and understand your own insurance plans and provisions.

I authorize my insurance benefits to be paid directly to Allergy & Asthma Associates.

I authorize Allergy & Asthma to release any medical or other information to my insurance company if requested.

“NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov. “

Signature & Date

Print Patient's Name _____



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A strong odor can be a dangerous trigger to patients with asthma and allergies. Please do not wear perfumes or fragrant lotions when visiting our office. Also, while in our office you may not use nail polish, polish removers, glues or other items with strong odors.

Thank you for your cooperation!
Allergy & Asthma Associates



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PARKING INFORMATION AND DIRECTIONS TO ALLERGY & ASTHMA ASSOCIATES

PARKING RATES

Between 0-20	Minutes	FREE
Between 20-60	Minutes	\$ 3.00
Between 1-2	Hours:	\$ 4.00
Between 2-3	Hours:	\$ 5.00
Between 3-4	Hours:	\$ 6.00 Maximum

DIRECTIONS

Our medical office is located at **27800 Medical Center Road, Suite 244 in Mission Viejo**. We are across the parking lot from Mission Hospital / Children's Hospital at Mission in the white brick medical office building.

From the 5 / 405 freeway exit Crown Valley Parkway and proceed East (left if Southbound, right if Northbound) to Medical Center Road. This is one stop light past the entrance to the Shops at Mission Viejo (formerly Mission Viejo Mall). Turn right on Medical Center Road and proceed up the hill. Turn left into the driveway for Mission Hospital and the Medical Offices. The medical offices are on your right and are numbered 1-3 starting at the street. Building 3 is at the far end of the lot. When you enter the building, go to the left side corridor for the elevator to the 2nd floor. For stairs take the right side corridor to the first door, go up one flight to the 2nd floor. Suite 244 is located on the "bridge" connecting Building #2 and #3. There is ample parking at the front, side and back of Building 3.

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