

Patient Registration Form- Yearly update 2024

(Please complete in its entirety to ensure proper billing and insurance payment)

Portland Asthma Allergy 2024

1. Please bring insurance cards, photo ID and all new patient paperwork filled out in its entirety.
2. Bring all medication or a complete list of your current medications, including over the counter medications and supplements.
3. Please arrive 30 minutes before your appointment time and allow up to 1.5 hours for your first appointment.
4. Please call 48 hours in advance if you need to cancel or reschedule to avoid a \$50.00 no show fee and potential cancellation of your referral.
5. If you have any symptoms of Covid or another respiratory illness, please call the clinic and speak to a member of the nursing staff prior to coming in for your appointment.
6. Cash pay and co-pay are expected at the time of service.
7. Young adults under the age of 18 are required to bring a parent or legal guardian.
8. Failure to comply with any of the requirements above will result in cancellation of your appointment.

Southeast: 8740 SE Sunnybrook Blvd # 300, Clackamas 97015 PH 971-358-5600
Southwest: 9370 SW Greenburg Rd # 311, Portland 97223 PH 503-245-8060
Northeast: 2150 NE Division Street # 202, Gresham, 97030 PH: 971-358-5800
Fax Number for all locations: 971-358-5801

All fields need to be filled out even if we have a copy of your insurance card:

***Legal Name:** _____ **Preferred Name:** _____

***Legal Sex:** M or F(circle one) **DOB:** _____ **Pronouns:** _____

Address: _____

Occupation: _____ **Social Security number :** _____

Phone # _____ **Email:** _____

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(signature on this form gives us permission to text or email based on clinic needs, and not used for marketing purposes)

Responsible Party if under 18: _____

Responsible Party Employer: _____ Phone# _____

DOB: _____ Relationship _____

(Please provide even if you are giving us your insurance card)

Primary

Insurance: _____ ID# _____ Grp:# _____

Policy Holder's Name: _____ DOB: _____

Secondary Insurance (if applicable)

Insurance: : _____ ID# _____ Grp# _____

Policy Holder Name: _____ DOB: _____

Preferred Pharmacy: _____ Location/Ph # _____

Emergency Contact: _____ Ph# _____

Referring Provider/PCP: _____

Releasing information to other parties including insurance companies and adults over 18 that are still on parent's insurance:

I (Signature) _____ authorize Portland Allergy & Asthma to share and/or release my **medical/billing information** to the following individuals: I understand that I can cancel this consent at any time (in writing to Portland Allergy & Asthma) but that canceling it will not affect any information that has already been released. **PLEASE PRINT ALL NAMES LISTED BELOW. PLEASE DO NOT LIST PHYSICIANS. (If no name is listed below, this means we can only discuss information with patients only.)**

Name: _____ Ph# _____ Relationship: _____

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Name: _____ **Ph#** _____ **Relationship:** _____

Or, I decline permission to discuss my medical/financial information with others outside of insurance companies or medical providers. _____ **(Initial)**

Clinic and Financial Policies:

1. I understand it is my responsibility to pay my copay at every visit, or I may incur a \$20.00 billing charge. _____ **(initial)**

2. I understand that there is a **\$50.00** no-show fee incurred for any office visit appointments not canceled with more than 24 hours' notice, and a **\$100.00** no show fee for any procedure not canceled with more than 24 hours' notice. Failure to pay no show fee and 2 or more no shows will result in discharge from the practice. _____ **(initial)**

3. I understand that although Portland Allergy and Asthma will provide me with good faith estimates, when requested by the patient prior to the appointment, it is my responsibility to coordinate benefits with my insurance company for Allergy/Asthma services covered under my plan, and primary care physician if a referral is needed prior to being seen. It is my responsibility to contact my insurance to determine if office visits, testing, serum, injections, and treatments are covered under my plan and how they are covered (if subject to my deductible, copay, and coinsurance) and to verify if my insurance/plan is network with Portland Allergy and Asthma before any services are done. . _____ **(initial)**

4. I understand that if my account falls into a delinquent status, I will be unable to make further appointments, fill/refill prescriptions or get allergy/venom shots until my account is brought current. _____ **(initial)**

5. I understand that although Portland Allergy and Asthma will do the best to work with me on my financial matters, if my account is delinquent for over 120 days, I will be sent to collections and understand that the collection agency will have additional fees and may include a judgment over and above my balance. At that point I will be discharged from the practice. _____ **(initial)**

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6. I understand that Portland Allergy and Asthma charges a **\$50.00 NSF** fee for any payments returned from the bank, and that I will then need to pay Cash or Credit/Debit Card moving forward. Should I not pay this fee, I will be discharged from the practice. _____ **(initial)**

7. Oral immunotherapy patients, **there is a non-refundable fee of \$25.00*** that will be charged at each of your appointments that you receive take home doses. This fee includes time involved in creating your customized daily doses as well as the food and medical supplies involved during the desensitization process while the patient is on food solution.

*Supply charges are not covered by insurance and must be paid on or before your appointment.

High Deductible Plans

PDX- Allergy & Asthma recognizes the challenging times we are all facing. We are available to speak with you and can assist you with making arrangements to pay your bill. Please reach out to us if you have any questions or concerns. A deductible deposit will be requested for services if your remaining deductible is over \$1000.00. You will be required to pay a 20% Deposit before the services can be done. We will collect 20% of the total services cost or 20% of remaining deductible balance; whichever is lower for the Deductible Deposit amount. If payment arrangements are needed, we ask that they be set up within 15 days from receiving your bill and prior to statement due date; whenever the bill cannot be paid in full at the time of the first billing statement.

When Payment Plans are set up, they are set up for the patient balance at that time. Any future visits will not be included in the monthly payment plan. You will be responsible for paying for all future visits in full, in addition to your monthly payment plan.

If, at any time, any of your future visits are over \$300.00, please contact the Billing Department to see if we can combine it with your existing payment plan. Anytime there are new balances added to your existing payment plan, we will have to increase the

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monthly payment plan amount. The account guarantor is responsible for making appropriate financial arrangements with the Billing Department.

If payment arrangements are needed: Please call our Billing Department at 971-358-5800 Option 2 to set up a payment plan.

Online payments can be made at <https://www.portland-allergy.com/>

Agreement/Authorization

My signature below indicates that I accept and understand the above policies and give Portland Allergy and Asthma permission to speak with and bill my insurance company on my behalf, including the release of needed medical information. I also hereby authorize payment of medical benefits to Portland Allergy and Asthma when an assigned claim is filed.

Patient/Responsible Party

Signature: _____

Date

signed: _____

- I understand I can revoke this authorization at any time by written notice of my decision to:
- Portland Allergy and Asthma, ATTN: Angie M. 8740 SE Sunnybrook Blvd Suite 300 Clackamas, Or 97015.
- If I withdraw this authorization, Portland Allergy and Asthma may not afterwards disclose my information for the purpose listed above. However, I cannot retroactively revoke authorization if disclosure has already occurred. Should I revoke this authorization in regards to my insurance company, I understand that I will be responsible for 100% of my bill due to the practice of not being able to bill the insurance company without authorization.

Enter Name _____

Today's Date: _____

Enter Address _____

Patient's Name: _____

Enter City/State/Zip _____

FOR PATIENTS:

Take the Asthma Control Test™ (ACT) for people 12 yrs and older. Know your score. Share your results with your doctor.

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for your total.

Step 3 Take the test to the doctor to talk about your score.

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5
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SCORE

2. During the past **4 weeks**, how often have you had shortness of breath?

More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5
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3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	1	2 or 3 nights a week	2	Once a week	3	Once or twice	4	Not at all	5
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4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day	1	1 or 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5
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5. How would you rate your **asthma** control during the **past 4 weeks**?

Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5
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TOTAL

Copyright 2002, by QualityMetric Incorporated.
Asthma Control Test is a trademark of QualityMetric Incorporated.

If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.

FOR PHYSICIANS:

The ACT is:

- A simple, 5-question tool that is self-administered by the patient
- Clinically validated by specialist assessment and spirometry¹
- Recognized by the National Institutes of Health

Health History



Questionnaire

Patient Name: _____

Age: _____ Date of Birth: _____ Sex: M ___ F ___

Primary Care Provider: _____

Preferred Pharmacy/Address: _____

Pharmacy Phone #: _____ Fax #: _____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. Base your answers on your own observations and not on what others have told you or what you may have assumed on the basis of previous allergy tests. Please complete this form before seeing the allergist as the information will organize your thinking and help us to understand your problem.

What are the problems that bring you to an allergist?

Please indicate the symptoms you experience:

<u>EARS</u>	Yes	No
Itching	()	()
Fullness	()	()
Popping	()	()
Tubes placed	()	()
Hard of hearing	()	()
Frequent infections	()	()
# ear infections/year _____		

<u>THROAT</u>	Yes	No
Soreness	()	()
Post-Nasal Drip	()	()
Itching of Palate	()	()
Recurrent Strep infections	()	()
Hoarseness	()	()
Tonsils	()	()
Adenoids removed	()	()

<u>NOSE/SINUS</u>	Yes	No
Repeated Sneezing	()	()
Watery discharge	()	()
Stuffy nose	()	()
Itching	()	()
Nasal trauma	()	()
Bloody nose	()	()
Poor sense of smell	()	()
Mouth breathing	()	()
Bad breath	()	()
Snoring	()	()

<u>EYES</u>	Yes	No
Contact Lenses	()	()
Itching	()	()
Burning	()	()
Watering	()	()
Swelling	()	()
Redness	()	()
Discharge	()	()
Glaucoma	()	()
Cataract	()	()

How many times a year are you treated with antibiotics for nasal/sinus infections? _____

For how long each time? _____

Date of last sinus x-rays? _____ Date of last CT scan of sinuses? _____

Date of any sinus surgery _____

<u>CHEST</u>	Yes	No
Cough	()	()
Wheezing	()	()
Sputum (phlegm)	()	()
Shortness of breath	()	()
at rest	()	()
with exercising	()	()
Coughed up blood	()	()
History of bronchitis	()	()
History of pneumonia	()	()
Positive TB skin test	()	()

<u>SKIN</u>	Yes	No
Eczema	()	()
Hives	()	()
Swelling	()	()
Infections	()	()

(boils, impetigo)

Names(s) of skin soap(s)/shampoo(s)/moisturizers used? _____

Date of last chest x-ray: _____

Result: _____

Do you have problems wearing LATEX GLOVES _____

or using latex products? (specify) _____

Date of last pulmonary function studies: _____

Result: _____

ASTHMA HISTORY

Have you ever been intubated, placed in intensive care, or on a respirator for asthma? _____

of hospitalizations for asthma: _____ # of emergency room visits for asthma in the last year: _____

Number of courses of oral steroids (Prednisone/Medrol) taken for asthma in the past year: _____

Do you have a peak flow monitor? _____ What is your best peak flow reading: _____

of times per month awakened with asthma (chest tight/wheeze/cough/short of breath) _____

of times per week you need to use inhaler for acute asthma (beyond scheduled doses) _____

Is your asthma worse at school or work? _____

SEASONAL INCIDENCE

Please indicate your age when symptoms first appeared and check off the months in which the symptoms occur.

	<i>Age of onset:</i>	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing	()	()	()	()	()	()	()	()	()	()	()	()	()
Coughing	()	()	()	()	()	()	()	()	()	()	()	()	()
Nasal	()	()	()	()	()	()	()	()	()	()	()	()	()
Eye	()	()	()	()	()	()	()	()	()	()	()	()	()
Hives	()	()	()	()	()	()	()	()	()	()	()	()	()
Eczema	()	()	()	()	()	()	()	()	()	()	()	()	()
Other	()	()	()	()	()	()	()	()	()	()	()	()	()

Are symptoms worse after exposure to:

- () Raking leaves () Humidity/heat () Cigarette smoke () Medications
- () Lawn mowing () Cold air () Perfumes
- () Hay/compost () Air conditioning () Strong odors
- () Damp basement () Weather changes () Newsprint
- () Animals/Pets () Smog (exhaust fumes) () Foods

ENVIRONMENT

How long have you lived in the Pacific Northwest? _____

Prior states(s)? _____

Type of home _____ How old is home? _____ How long lived there? _____

Location of home () Country () Suburb () City

Basement () yes () no What is the basement used for? _____

Is basement () dry () damp

Does anyone at home smoke? () yes () no

Who? _____ How much? _____

ANIMALS:

Do you have any pets? () yes () no

If yes, please list: _____

How long have the pets been with you? _____

Does the animal have full use of the house? () yes () no

Does the animal sleep on the patient's bed? () yes () no

Does animal exposure make symptoms worse? () yes () no

PATIENT'S BEDROOM:

Mattress	Pillow(s)
Age: _____ years	Age: _____ years
Type:	Type:
Innerspring cotton ()	Feather ()
Foam ()	Foam rubber ()
Other _____	Synthetic ()
	Buckwheat ()

INSECT ALLERGY

After a bee sting do you have problems with:

- | | | | | | |
|----------------|-----|-----|-------|-----|-----|
| | Yes | No | | Yes | No |
| Local swelling | () | () | Hives | () | () |

IMMUNIZATIONS:

Yes	No	Date(s)	
Childhood series	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumovax	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken Pox Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HEALTH HISTORY

Mother	Father	Brother(s)	Sister(s)	Children	Grandparent(s)		
Hay Fever/Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Bronchitis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other chronic illnesses, (i.e., heart, lung, kidney) or diseases? _____

SOCIAL HISTORY

Married Single Divorced Widowed

Occupation of patient: _____

Briefly describe workplace/school environment:

Number of days work/school missed in last year: _____

Does the patient consume alcoholic beverages? yes no

If yes, type and frequency? _____

Does the patient smoke? Current Former Never

If yes, how many packs/day? _____

Please list your hobbies and/or spare time activities:

THIS SECTION TO BE COMPLETED BY PHYSICIAN

R.O.S. _____	
Eyes _____	Lungs _____
Ears _____	Heart _____
Nose _____	Abdomen _____
Sinus _____	Extremities _____
Oropharynx _____	Skin _____
Neck _____	

POEM for self-completion and/or proxy completion

Patient Details: _____

Date: _____

Please circle one response for each of the seven questions below about your/your child's eczema. If your child is old enough to understand the questions then please fill in the questionnaire together. Please leave blank any questions you feel unable to answer.

1. Over the last week, on how many days has your/your child's skin been itchy because of the eczema?

No days 1-2 days 3-4 days 5-6 days Every day

2. Over the last week, on how many nights has your/your child's sleep been disturbed because of the eczema?

No days 1-2 days 3-4 days 5-6 days Every day

3. Over the last week, on how many days has your/your child's skin been bleeding because of the eczema?

No days 1-2 days 3-4 days 5-6 days Every day

4. Over the last week, on how many days has your/your child's skin been weeping or oozing clear fluid because of the eczema?

No days 1-2 days 3-4 days 5-6 days Every day

5. Over the last week, on how many days has your/your child's skin been cracked because of the eczema?

No days 1-2 days 3-4 days 5-6 days Every day

6. Over the last week, on how many days has your /your child's skin been flaking off because of the eczema?

No days 1-2 days 3-4 days 5-6 days Every day

7. Over the last week, on how many days has your/your child's skin felt dry or rough because of the eczema?

No days 1-2 days 3-4 days 5-6 days Every day

Total POEM Score (Maximum 28): _____

POEM for self-completion and/or proxy completion

How is the scoring done?

Each of the seven questions carries equal weight and is scored from 0 to 4 as follows:

No days	= 0
1-2 days	= 1
3-4 days	= 2
5-6 days	= 3
Every day	= 4

Note:

- If one question is left unanswered this is scored 0 and the scores are summed and expressed as usual out of a maximum of 28
- If two or more questions are left unanswered the questionnaire is not scored
- If two or more response options are selected, the response option with the highest score should be recorded

What does a poem score mean?

To help patients and clinicians to understand their POEM scores, the following bandings have been established (see references below):

• 0 to 2	= Clear or almost clear
• 3 to 7	= Mild eczema
• 8 to 16	= Moderate eczema
• 17 to 24	= Severe eczema
• 25 to 28	= Very severe eczema

Do I need permission to use the scale?

The POEM scale is protected by copyright. Commercial users must pay a per patient fee – details are available at <https://licensing.micragateway.org/product/poem--patient-orientated-eczema-measure>

POEM remains freely available for non-commercial use and can be downloaded from:

www.nottingham.ac.uk/dermatology

We do however ask that you register your use of the POEM by e-mailing cebd@nottingham.ac.uk with details of how you would like to use the scale, and which countries the scale will be used in.

References

Charman CR, Venn AJ, Williams HC. The Patient-Oriented Eczema Measure: Development and Initial Validation of a New Tool for Measuring Atopic Eczema Severity From the Patients' Perspective. Arch Dermatol. 2004;140:1513-1519

Charman CR, Venn AJ, Ravenscroft JC, Williams HC. Translating Patient-Oriented Eczema Measure (POEM) scores into clinical practice by suggesting severity strata derived using anchor-based methods. Br J Dermatol. Dec 2013; 169(6): 1326–1332.

RHINITIS CONTROL ASSESSMENT TEST (RCAT)

PATIENT NAME: _____

DATE COMPLETED: _____

PLEASE CHECK THE CATEGORY THAT BEST ANSWERS THE QUESTION.

Write the score for each item in the column to the right.

1. During the past WEEK, how often did you have nasal congestion?

Never	Rarely	Sometimes	Often	Extreme ly Often	SCORE
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	

2. During the past WEEK, how often did you sneeze?

Never	Rarely	Sometimes	Often	Extreme ly Often
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

3. During the past WEEK, how often did you have watery eyes?

Never	Rarely	Sometimes	Often	Extreme ly Often
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

4. During the past WEEK, to what extent did your nasal or other allergy symptoms interfere with your sleep?

Never	Rarely	Sometimes	Often	Extreme ly Often
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

5. During the past WEEK, how often did you AVOID any activity (for example, gardening, exercising, visiting a house with a dog or cat) because of your nasal or other allergy symptoms?

Never	Rarely	Sometimes	Often	Extreme ly Often
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

**TOTAL
SCORE**

The higher the score, the better controlled you are with your nose and eye symptoms.

A score that is **lower** than **21** suggest that you are not well-controlled.

REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ Date: _____

For recent symptoms *related to your visit today*. Please review and check all that apply.

General

- Fever
- Weight loss
- Weight Gain
- Fatigue
- Night Sweats
- Frequent Infections
- Headaches

Skin

- Rash
- Hives
- Itching
- Hair loss
- Dry Skin
- Eczema

Allergies

- Seasonal
- Year long
- Food Allergies

Ears/ Nose/ Throat

- Nasal Congestion
- Sore Throat
- Postnasal Drip
- Runny Nose
- Ear Pain

Eyes

- Redness
- Pain
- Itching
- Watering
- Blurred Vision

Respiratory

- Wheezing
- Coughing
- Shortness of Breath
- Chest Tightness
- Sputum Production

Cardiovascular

- High Blood Pressure
- Medication name _____
- Dizziness
- Chest Pain
- Swelling in feet/legs
- Heart Palpitations

GI (Food Allergy Visit Only)

- Abdominal Pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Heartburn
- Bloating

Cancer

- History of Cancer
- Type _____

Hematologic (Immunology Visit Only)

- Easy Bleeding
- Easy Bruising
- Anemia
- Abnormal blood tests
- Blood Clots

Other
