THE ADULT AND CHILD ALLERGY - ASTHMA MEDICAL CLINIC， INC。

330 S. Garfield Ave,. Ste 116, Alhambra, CA 91801 Ph: (626) 284-3400 Fax: (626) 284-3434
1850 S. Azusa Ave,. Ste 206, Hacienda Heights, CA 91745 Ph: (626) 810-5450 Fax: (626) 810-0391

PATIENT INFORMATION FOR MEDICAL RECORD (PLEASE PRINT)

NAME ____ DATE OF BIRTH ___________________
LAST FIRST M I

HOME ADDRESS ____

CITY ______________________________________STATE _________________ZIP CODE ____________________

HOME PHONE (_____) ______________________ WORK PHONE (________) _________________________x______

CELL PHONE (_____) ________________________ SOCIAL SECURITY # __________________ SEX M / F

EMPLOYER __________________ OCCUPATION ____________________ E-MAIL ADDRESS _________________

MARITAL STATUS： ___MINOR ___SINGLE ___MARRIED ___SEPARATED ___DIVORCED ___WIDOWED

REFERRED BY __________________________________ FAMILY PHYSICIAN _______________________________

EMERGENCY CONTACT

NAME： __________________________ PHONE ： ____________________RELATIONSHIP： _________________

FINANCIAL INFORMATION

GUARANTOR NAME ____ DATE OF BIRTH: ______________

ADDRESS (IF DIFFERENT FROM ABOVE) ____

HOME PHONE (________) __________________WORK PHONE (________) __________________________x________

SOCIAL SECURITY # ______________________________ DRIVER'S LICENSE # _____________________________

PLEASE SIGN AND RETURN TO RECEPTIONIST

I，THE UNDERSIGNED，HAVE INSURANCE COVERAGE WITH ______________________ AND ASSIGN DIRECTLY TO DR。 STEPHEN WONG ALL MEDICAL BENEFITS，IF ANY THEREFORE PAYABLE TO ME FOR THE SERVICES RENDERED。 I UNDERSTAND THAT I AM FINANCIALY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE。 I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS。

SIGNED ____________________________________ **DATE** _______________________

NOTE： PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE COURSE OF TREATMENT。

TODAY'S DATE: ____________________

___	W/ Referral
___	W/O Referral

INSURANCE INFORMATION

Name of Patient: ____ Acct #: ____________ D.O.B: ______________

Name of Insurance Company: ____ PPO HMO POS EPO

Name of Primary Card Holder: ____ D.O.B.: _________________

Subscriber ID #: ____ Group #: ____________________________

Name of Employer/School: ____

Relationship to Patient: ___ Self ___ Spouse ___ Father ___ Mother ___ Other

DO NOT FILL OUT BELOW! OFFICE USE ONLY!

Insurance Address: ____

City: ____________________________________ State: _______________ Zip Code: _____________

Insurance Phone #: _____________________________

Effective Date: _________________________________ Is patient currently eligible? YES NO

If not, termination date: _________________________

Co-payment: $___________ Deductible: $______________ Family Ded: $________ Met: $ __________

Medical Group: ____ PCP: ______________________________

Type of Coverage

Office Visits: ____

Allergy Testing: ____ Rast Test: Yes No

Allergy Injections: ____ Pre-Cert: Yes No

Antigens: ____ Pre-Cert: Yes No

Laboratory: ____

Flu Vaccine: ____

**Special Notes: ____

____

____

Does Patient have a Pre-Existing condition: Yes No

If Yes, what are they: ____

Pre-Cert for CT Scan: Yes No (If yes, Phone #: ____)

Referral from PCP/INS: Yes No (How long is referral good for: ___________________________)

Date of Verification: _______/ ________/ _________ By Whom: _______________________________

The Adult and Child Allergy – Asthma Medical Clinic. Inc.

330 S Garfield Ave., Suite #116, Alhambra, CA, 91801 P: 626.284.3400 F: 626.284.3434
1850 S. Azusa Ave., Suite #206, Hacienda Heights, CA, 91745 P: 626.810.5450 F: 626.810.0391

Name: ____________________________________ Age: _______ Date of Birth:_________

I. **Major Problem for Visit (C\ YW_ YES or NO)**

A.) Nose Problems	YES	NO
B.) Chest Problems	YES	NO
C.) Skin Problems	YES	NO
D.) Ear Problems	YES	NO
E.) Eye Problems	YES	NO
F.) Other Problems: ___________________		

II. Allergies to Drugs?

Name of Drug: ________________________________ Reaction: ________________________

III. Symptoms

A. Chest (C\ YW_ YES or NO)

1.) Wheezing	YES	NO
2.) Chronic Cough	YES	NO
3.) How many days of school/work did you or your child miss in the past six months because of wheezing? ______________________		
4.) Have you been hospitalized for asthma?	YES	NO

B.) Upper Respiratory Symptoms (7\ YW_ YES of NO)

1.) Frequent nose congestion	YES	NO
2.) Frequent discharge from nose	YES	NO
3.) Frequent ear infections	YES	NO
4.) Mouth breathing	YES	NO
5.) Frequent sneezing	YES	NO
6.) Noisy breathing/snoring during sleep	YES	NO
7.) At what age did the nasal problem start?	______________	

C.) Eyes (C\ YW_ YES or NO)

1.) Redness/Itching	YES	NO
2.) Discharge	YES	NO
3.) When did these symptoms starts?	________________	

D.) Skin (C\ YW_ YES or NO)

1.) Eczema (allergic skin rash)	YES	NO
a.) Only as infant/child	YES	NO
b.) Now?	YES	NO
2.) Hives, Welts	YES	NO
3.) Dry Skin	YES	NO
4.) when did these problems start?	________________	

E.) Gastrointestinal (7\ YW_ YES or NO)

1.) Frequent Episodes of nausea, vomiting, abdominal cramps, bloating, diarrhea.	YES	NO

A.) Associated with specific foods?
Please list: ____

2.) Rash, Hives	YES	NO

A.) Associated with specific foods?
Please list: ____

F.) Stinging Insect Allergy (C\ YW_ Yes or NO)

1.) Reaching to bee, hornet, wasp or yellow jacket sting.	YES	NO

A.) Describe reaction: ____________________

IV. Relationship of Symptoms to Possible Causes

1.) Seasonal difference between winter, spring, summer or fall? YES NO

A.) Specify changes in symptoms: ____________________

2.) Are symptoms worse during day or night or the same? ____________________

3.) Symptoms increase with (Ô@&\ YES or NO)

A.) Wind YES NO
Symptoms: ____________________

B.) Rain YES NO
Symptoms: ____________________

C.) Mowing Lawn or playing in grass YES NO
Symptoms: ____________________

D.) Vacuuming, house dust YES NO
Symptoms: ____________________

F.) Colds or infections YES NO
Symptoms: ____________________

G.) Exposure to animals YES NO
Symptoms: ____________________

H.) Weather YES NO
Symptoms: ____________________

I.) Smog YES NO
Symptoms: ____________________

J.) Odors YES NO
Symptoms: ____________________

K.) Running YES NO
Symptoms:____________________

L.) Tension, emotional upset YES NO
Symptoms: ____________________

M.) Laughter/Excitement YES NO
Symptoms: ____________________

V. Family History

Symptoms	**Relationship to Patient**		
1.) Asthma	____________________	YES	NO
2.) Bronchitis	____________________	YES	NO
3.) Emphysema	____________________	YES	NO
4.) Nose Allergy/ Hay Fever	____________________	YES	NO
5.) Hives	____________________	YES	NO
6.) Skin allergies/ Eczema	____________________	YES	NO
7.) Cystic Fibrosis	____________________	YES	NO

VI. Environment

A.) Pet (C\ YW_ YES or NO)

Dog	YES	NO	Cat	YES	NO
Horse	YES	NO	Rabbits	YES	NO
Birds	YES	NO	Others.	YES	NO

B.) Does anyone smoke at home? YES NO

VII. Treatments

A.) Previous allergy skin testing or blood test? YES NO

1.) When: ____________________

B.) Have you received allergy shots in the past? YES NO

1.) For how long? ____________ Effective? YES NO

C.) List of all current medications: ____________________

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