



The Center at University Pointe

IMPORTANT INFORMATION ABOUT YOUR APPOINTMENT

Welcome to University Sinus & Allergy. Please complete the attached registration form and patient history and bring them with you at the time of your appointment.

Your first examination may require skin allergy testing. In the event you are allergy tested, all oral antihistamines or decongestant medications (such as over-the-counter cold remedies, sinus preparations, or allergy medicines) should be **discontinued for 7-10 days** before your visit.

Please check with your insurance carrier to ensure our physicians are in your network. If your insurance company requires a referral from a primary care physician, please be sure to obtain this prior to your appointment. A copy of your insurance will need to be obtained, please have your insurance card with you at the time of your service. Payment for services, or your co-payment (if applicable), are appreciated at your appointment.

Your initial evaluation will require three hours. Because we set aside this large block of time for your appointment, we request if you are unable to keep your appointment, please notify us as soon as possible.

Once again, welcome to our office. Should you have any questions, please call us at 513/475-8400. Please read over the enclosed brochure as it provides more detailed information regarding your visit.

We look forward to seeing you at our office.

Thank you,

University Sinus & Allergy
Allen M. Seiden, MD
Lawrence J. Newman, MD
Steven S. Sutton, MD
Lee A. Zimmer, MD

University Sinus AND Allergy

The Center at University Pointe

Date: _____ Physician being seen: _____

Patient's Legal Name: _____

Name you would like to be called: (Nickname) _____ Social Security#: _____

Date of Birth: _____ Sex: M or F Marital Status: Married Single Divorced Separated
Race: _____ (Circle One) (Circle One)

Address: _____ Apt./Unit# _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ Cellular / Pager #: (_____) _____
(circle one)

Employer: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address (if available): _____ How did you hear about us? _____

Referring Physician: _____ Primary Care Physician: _____

Address: _____ Address: _____

Nearest friend or relative: _____ Phone #: (_____) _____

Relationship to Patient: Spouse Parent Grandparent Daughter Son Friend Other: _____
(Circle one)

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: Name of Insurance Company: _____

Insurance ID#: _____ Insurance Phone Number: _____

Name of Primary Person Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____ Phone #: (_____) _____

Relationship to Cardholder: Self Spouse Parent Grandparent Other: _____ (Circle One)

Secondary Insurance: Name of Insurance Company: _____

Insurance ID#: _____ Insurance Phone Number: _____

Name of Primary Person Insured: _____ Employer: _____

Social Security #: _____ Date of Birth: _____ Phone #: (_____) _____

Relationship to Cardholder: Self Spouse Parent Grandparent Other: _____ (Circle One)

Is this injury related? Yes No Date of injury: _____

Type of injury: Motor Vehicle At Work Pedestrian Animal Bite Other _____

Do you have the injury related coverage information other than health insurance? Yes No

May we discuss your healthcare with someone other than yourself? Yes No

If yes, whom may we discuss it with: _____

Relationship to patient: Spouse Parent Grandparent Daughter Son Friend Other: _____
(Circle one)

May we leave test results, etc. on your answering machine if you are not available? Yes No

Statement to permit payment of Medicare/Insurance benefits to provider, physicians, and patient

I authorize you to give me reasonable and proper medical care by today's standards. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or other health insurance company any information needed for this or a related Medicare claim or other health insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize and direct the health insurance company to issue payment check(s) directly to the physician(s) rendering the covered services. I understand it is mandatory to notify the health provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. I hereby claim the amount of indemnity specified in my contract with my health insurance company. I realize that I am responsible for all coinsurance, deductibles, and non-covered services billed to me by either Allergy & Asthma Associates, Inc. or University Ear, Nose and Throat Specialists, Inc.

Signature _____ Date: _____

Allergy & Asthma Associates, Inc. & University Ear, Nose and Throat Specialists, Inc.

Patient History

Patient Name _____ Date of Birth ___/___/___ Date: _____

Married Single Divorced Separated Widow/er Child

Sex: M F Race: _____

Occupation _____ Hobbies _____

Others living in home (please list names and birth years):

Primary Complaint (Why are you here?) _____

How long have you had this problem? _____

Medications:

Do you have **any allergies** to drugs or medications? Yes No **Are you allergic to Latex?** Yes No

If yes, please explain: _____

List any **medications and dosage (prescription and/or herbal)** you are presently taking:

What medications **have helped**? _____

What medications have **not** helped? _____

Personal History: Have you had any of the following medical conditions, **now or in the past**?:

	Y	N		Y	N		Y	N		Y	N
allergies	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	scarring/keloids	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>	frequent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	seizures	<input type="checkbox"/>	<input type="checkbox"/>	infection/boils	<input type="checkbox"/>	<input type="checkbox"/>
hay fever	<input type="checkbox"/>	<input type="checkbox"/>	liver disease	<input type="checkbox"/>	<input type="checkbox"/>	glaucoma or cataracts	<input type="checkbox"/>	<input type="checkbox"/>	reaction to local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	visual problems	<input type="checkbox"/>	<input type="checkbox"/>	reaction to general anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
gastritis	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	bone or joint problems	<input type="checkbox"/>	<input type="checkbox"/>
esophagitis	<input type="checkbox"/>	<input type="checkbox"/>	heart problems	<input type="checkbox"/>	<input type="checkbox"/>	prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
immune problems	<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	urinary tract problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
positive TB test	<input type="checkbox"/>	<input type="checkbox"/>	cancer (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Briefly comment on any of the above conditions which have been checked: _____

Did you receive routine child immunizations? NO YES Are they up to date? NO YES

Have you ever had chicken pox? NO YES Chicken pox vaccine? NO YES

Infancy: A. Birth weight: _____ Did you have any health problems just after birth? YES NO

If yes, please describe: _____

B. Did you require a respirator or need oxygen as a newborn? YES NO

Diet: Until you were 6 months old, were you: breast fed bottle fed
 At what age were you first fed: Milk formula _____? Soy formula _____? Baby food _____? Table Food _____?
 Do you (or did you previously) strictly avoid particular foods? YES NO
 If yes, which foods and why? _____

Drug and Alcohol:

Have you ever used tobacco of any kind? YES NO If YES, type of tobacco: _____
 At what age did you start using tobacco? _____
 Do you smoke now? YES NO How many packs per day? _____
 If NO, how long ago did you quit _____
 Do you drink Alcohol? YES NO Approximately how much per week? _____
 Have you or do you use illicit drugs? YES NO If YES, type : _____

Prior Allergy or Sinus Testing:

Have you ever had allergy testing? YES NO If YES, when? _____
 Are you currently or have you ever had allergy shots? YES NO If YES, when? _____
 Have you ever had nasal or sinus surgery? YES NO If YES, when? _____
 If yes, please describe what type of surgery: _____
 Have you ever had sinus or lung CAT Scans or X-rays? YES NO
 If YES: What? _____ When? _____ Where? _____
 What? _____ When? _____ Where? _____
 What? _____ When? _____ Where? _____
 What? _____ When? _____ Where? _____

Major Illnesses / Previous Surgery / Hospitalizations:

Year	Illness / Surgery / Hospitalization
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History: Who in your immediate family have had any of the following medical conditions:

allergies _____ bronchitis _____ heart problems _____ thyroid problems _____
 asthma _____ high blood pressure _____ bleeding problems _____ bone or joint problems _____
 hay fever _____ psychiatric problems _____ liver disease _____ visual problems _____
 eczema _____ kidney disease _____ frequent heartburn _____ stomach ulcers _____
 allergic dermatitis _____ diabetes _____ tuberculosis _____ seizures _____
 hives _____ cystic fibrosis _____ immunologic problems _____
 cancer (type) _____ Other _____
 early childhood or unexplained deaths in the close family _____ please explain: _____

Briefly comment on any of the above conditions: _____

Allergy only

Triggers: Which of the following make your symptom worse? (check all that apply)

- colds/infection temperature changes laughter exercise raking leaves
- cold or damp odors house dust lawn mowing mildew
- fatigue rain or wind smoke or smog grass cats/dogs
- excitement anger/tension pregnancy foods other animals

Are you **Better** or **Worse**: At home: B W In air conditioning: B W On vacation: B W
 At work: B W Out of doors: B W Other: _____

Seasons: During which months are your symptoms troublesome? (check all that apply, underline if more severe)

- Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Same all year

Environment:

- 1. Do you have pets? YES NO If yes, what kind? _____
- 2. Does anyone smoke? YES NO If yes, who? _____
- 3. Do you have air conditioning? NO YES
- 4. Are there water damaged areas or mold (mildew) in your home? YES NO
- 5. Are you exposed to any unusual substances (chemicals, plastics, etc.) at work, school, home, or in a hobby? YES NO
If yes, please explain: _____
- 6. What type of pillows do you have? Feather Foam Synthetic Other: _____
- 7. What type of heat do you have? Forced Air Gravity Gas Electric Other: _____
- 8. How old is your home? _____

- Lung:**
- 1. Have you ever had a wheezing attack? YES NO If so: How frequently? _____
Last hospitalization for wheezing __ / __ / __ Last emergency room visit for wheezing __ / __ / __
 - 2. Have you had pneumonia? YES NO
 - 3. Have you had bronchitis? YES NO If so, how often? _____
 - 4. Do you cough frequently? YES NO If yes, is it daily? nightly? after meals?
 - 5. Do you cough or wheeze during (or after) exercise? YES NO
 - 6. Do you cough up blood? YES NO
 - 7. Do you ever have heartburn? YES NO
 - 8. Do you have fatty, greasy stools? YES NO 9. Unwanted weight gain or loss? YES NO
If yes, explain _____
 - 10. Do your chest problems discourage or prevent normal physical activity? YES NO
 - 11. Have you missed work (school) or sleep because of your chest problems? YES NO
If yes, how many days per month? _____ Per year? _____
 - 12. At what age did your chest problems begin? _____ Are they getting: better worse staying the same?

- Nose:**
- A. Please select the symptoms you have on a frequent basis:
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> nasal congestion | <input type="checkbox"/> runny nose | <input type="checkbox"/> headaches | <input type="checkbox"/> itchy nose |
| <input type="checkbox"/> trouble hearing | <input type="checkbox"/> nose rubbing | <input type="checkbox"/> ear infections | <input type="checkbox"/> itchy ears/eyes |
| <input type="checkbox"/> trouble smelling | <input type="checkbox"/> nosebleeds | <input type="checkbox"/> head colds | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> mouth breathing | <input type="checkbox"/> post nasal drip | <input type="checkbox"/> itchy throat | <input type="checkbox"/> sniffing |
- B. Do you tire easily when your nose is congested? YES NO
 - C. Have you ever had your tonsils/adenoids removed? YES NO Have you ever had tubes in your ears? YES NO
 - D. Do you have any problem tasting food? YES NO Is your sense of smell impaired? YES NO
 - E. Have you ever had nasal trauma or a broken nose? YES NO Head trauma? YES NO
 - F. Have you missed work or school because of your nose problems? YES NO? If yes, how frequently? _____
 - G. Have you missed sleep because of your nose problems? YES NO? If yes, how frequently? _____
 - H. How many ear infections have you had in the past 6 months? _____ 2 years? _____
 - I. How many sinus infections have you had in the past 6 months? _____ 2 years _____
 - J. At what age did your nose problems begin? _____ Are they getting: better worse staying the same?

- Skin:**
- A. Do you have a recurrent or frequent rash? YES NO If yes, does it itch? YES NO
 - B. Did you have eczema (allergic dermatitis) as a baby? YES NO
 - C. Have you ever had hives? YES NO If yes, what caused them? _____
 - D. Have you ever had swelling of your lips, hands, or feet? YES NO If yes, what caused them? _____
 - E. At what age did your skin problems begin? _____ Are they getting: better worse staying the same?

- Food/Drug/Insect:**
- Have you ever had an unusual or allergic reactions to any medicines? YES NO
 - Have you ever had an unusual or allergic reaction to insect stings? YES NO
 - Have you ever had an unusual or allergic reaction to aspirin? YES NO
 - Have you ever had an unusual or allergic reaction to alcohol? YES NO
 - Have you ever had an unusual or allergic reaction to sulfites/preservatives? YES NO
 - Have you ever had an unusual or allergic reaction to any foods? YES NO

If yes, please describe: _____

Physician Signatures: _____ Date: _____
 Allergy & Asthma Associates, Inc. University Ear, Nose and Throat Specialists, Inc.

DISCLOSURE TO FAMILY/FRIENDS

I hereby authorize _____
(Physician / UCP Practice) to discuss the following with the person/persons listed below.

- () Condition/Treatment/Plan of Care
- () Diagnostic Test Results
- () Lab Results

I understand that this authorization is voluntary and that it may include information relating to AIDS, HIV, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be re-disclosed by such person or entity.

Allowed person/persons

<u>Name</u>	<u>Relation</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

Patient Name / Legal Representative _____

Patient DOB: _____

Signature _____ Date _____

