Steven Tolber, MD
Pamela Daffern, MD

Advanced Allergy Associates of New Mexico

Teresa Jenkins-McCord, CANP
P James Romero, CFNP
Paul Tapia, PA-C

On behalf of the staff and providers of Advanced Allergy Associates of New Mexico Inc. we would like to welcome you to our practice and share with you our total commitment to providing exceptional patient care and compassionate service to all our patients and their families.

Our office is open Monday through Thursday from 8am to 5pm and on Fridays from 8am to 3pm. The office is closed every day from 12pm to 1pm for the lunch hour. Patients are seen by scheduled appointments only. Our allergy injections are offered on a walk in basis for our patients that are currently on immunotherapy. Patients will be directed to the appropriate On Call Provider when calling our office after hours, including weekends and holidays.

Please note we do not perform allergy testing on your first visit. Also please do not wear perfume, cologne, after shave or scented lotions as our patients may be allergic or sensitive to these fragrances and this could trigger an asthma attack.

We request that you complete the enclosed forms and either drop off, mail back or fax your forms 2 weeks before your visit. The information will assist us with your care. Fax number is 505-237-3632.

Before your visit, please check with your insurance provider to see if your plan requires a referral from your primary care physician. If yes this must be obtained prior to your visit. We require your referral on file with our office before your scheduled appointment, if we do not have your referral two days prior to your appointment we will need to reschedule your appointment.

When you arrive for your first appointment, please bring the following with you:

1. All of your health insurance cards (we will ask for them EVERY visit)
2. Photo identification
3. PCP Address and Phone Number
4. Medical Records pertaining to any previous Allergy or Asthma care
5. Any applicable co-pays

You will receive a call to remind you of your appointment time. You must arrive 30 minutes prior to your appointment time, please allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late. We strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

If you have any questions or special needs, please notify us prior to your visit. **We do require 24 hours notice if you are unable to keep a scheduled appointment.** It is our policy that after two (2) missed appointments we reserve the right to discharge you from our practice.

Thank you for choosing Advanced Allergy Associates of New Mexico Inc. for your healthcare needs.

Sincerely

The Providers and Staff of Advanced Allergy Associates Inc.

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PLEASE PRINT LEGIBLY ON ALL PAGES

Advanced Allergy Associates of NM

Patient Name: (First Name Middle Initial Last Name)	**Sex:**	**Date of Birth:**
Mailing Address: (Street City, State Zip)	**Home Phone:**	**Social Security #:**
Name of Employer:	**Work Phone:** «PWTele»	**Occupation:**
Primary Care Physician:	**Referring Doctor:**	

Race	☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White
Ethnicity	☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Language	☐ English ☐ Spanish ☐

Responsible Party

Name of Responsible Party:	**Date of Birth:**	**Social Security #:**	**Phone:**
Responsible Party Address:	**Responsible Party Employer:**		**Work Phone:**
Occupation:	**Relationship to patient:**		**Sex:** «GSex»

Emergency Contact

Emergency Contact:	**Relationship to patient:**	**Phone:**

Primary Insurance Coverage

Primary Insurance Company:	**Address:**		
Subscriber Name:	**Subscriber DOB:**	**Policy #:**	**Group #:**
Is this insurance through your employer? Yes ☐ No ☐	**Patient's relationship to insured:** Self ☐ Spouse ☐ Child ☐ Other ☐		

Secondary Insurance Coverage

Secondary Insurance Company:	**Address:**		
Subscriber Name:	**Subscriber DOB:**	**Policy #:**	**Group #:**
Is this insurance through your employer? Yes ☐ No ☐	**Patient's relationship to insured:** Self ☐ Spouse ☐ Child ☐ Other ☐		

Authorization

Authorization To Pay Benefits To Physician: I certify that I (or my dependent) have the above insurance coverage and assign directly to Advanced Allergy Associates of NM all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that if a referral is required by my insurance company it is my responsibility to obtain one from my primary care physician.

Patient/Responsible Party Signature _____ Date _____

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BILLING POLICY

Please bring your insurance card and present it for every appointment. At the time of visit, we require payment of any co-payment/co-insurance determined by the patient's insurance plan. Patients without health insurance are required to pay the total charge at the time of service.

It is the responsibility of the patient or guardian to verify that a Referral is valid at the time of service.
Some insurances require members to obtain a referral from their Primary Care Provider prior to their visit. If the patient does not have a valid referral, they can choose to still be seen without a referral or reschedule the appointment. If you choose to be seen without a referral, you will be asked to sign a waiver and will be responsible for payment at the time of service.

If we are not contracted with your insurance plan, we will not be responsible for collecting from your insurance company nor negotiating a settlement of a disputed claim. We cannot wait for disputed or pending claims to pay. You are responsible for payment within 45 days of service.

Our policy requires that a patients account is paid within 30 days from the first receipt of a statement. It is the responsibility of the patient or guardian to ensure payment is made. There will be a $25.00 service charge for all returned checks.

It is your responsibility to request a cost estimate for skin testing prior to your skin testing appointment. Please familiarize yourself with the benefits of your insurance plan.

Patients who are on immunotherapy or Xolair injection schedules are required to pay their account in full monthly. All other services are required to be paid at the time of service.

You may not take your allergy extract from this office until the patient portion is paid in full.

We call to verify appointments 48 hours prior to your visit to confirm you are coming. Please call us back at least 24 hours before your appointment to confirm if we could not reach you and have left you a message. If we do not hear back from you within 24 hours prior to your appointment time, your appointment may be cancelled and you will be asked to reschedule.

Patients who carry health insurance should remember that professional services are rendered and charged to both you and your insurance company. Please be familiar with your specific insurance plan, what it covers and if you are required to have a referral prior to your visit. You should also be familiar with the participating providers for your insurance plan including laboratories and x-ray facilities as you are ultimately responsible for the entire bill.

I have read and understand the terms of the billing policy as outlined above.

Patient/Guardian Signature: _____ Date_____

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NEW PATIENT QUESTIONNAIRE

Patient Name_____ Birth Date_____ Date _____

What is the reason for your visit? _____

Referring Provider _____ Primary Provider _____

Pharmacy Name, Address, and Phone _____

PAST MEDICAL HISTORY: (Do you presently have or have ever had the following conditions?)

	Yes	No		Yes	No
Allergies	___	___	Hepatitis	___	___
Anemia	___	___	HIV/AIDS	___	___
Anxiety Disorder	___	___	Hives	___	___
Arthritis	___	___	Hypercholesterolemia	___	___
Asthma	___	___	Hypertension	___	___
Bleeding disorder	___	___	Kidney Disease/Decreased Function	___	___
Blood Disease	___	___	Liver disease	___	___
Bowel/Intestinal Disorder	___	___	Lung Disease	___	___
Cancer	___	___	Migraine Headache	___	___
Cataract	___	___	Neurological disorder	___	___
Congestive Heart Disease	___	___	Osteoporosis	___	___
COPD	___	___	Pneumonia	___	___
Crohn's Disease	___	___	Psychiatric disorder	___	___
Depression	___	___	Seizure Disorder	___	___
Diabetes Mellitus	___	___	Sinusitis	___	___
Frequent Bronchitis	___	___	Sleep Apnea	___	___
Frequent Strep Throat	___	___	Stomach Ulcer/Duodenal Ulcer	___	___
Gastroesophageal Reflux Disease	___	___	Stroke/Mini Stroke	___	___
Glaucoma	___	___	Thyroid Disease	___	___
Heart Problems	___	___	Tuberculosis	___	___

PAST SURGICAL HISTORY:

Type of Surgery	Location (Right, Left, Bilateral)	Year

Have you had any recent chest or sinus x-rays or CT Scans? Yes No If yes, When? Where?

Have you had any recent lab work? Yes No If yes, When? Where?

FAMILY HISTORY:

Please check if mother, father, siblings, or children have any of these diseases/disorders, please put their first name for siblings and/or child (ren). Please indicate the age of onset and/or death and specify.

	Mother	Father	Brother (First Name)	Sister (First Name)	Child(ren) (First Name)
Asthma					
Sinus Disease					
Hay Fever/Allergies					
Cystic Fibrosis					
Emphysema/COPD					
Thyroid Disease					
Heart Disease					

Diabetes					
High Cholesterol					
	Mother	**Father**	**Brother (First Name)**	**Sister (First Name)**	**Child(ren) (First Name)**
High Blood Pressure					
Cancer; Type					
Other Disease/Disorder					

SOCIAL HISTORY:

Do you use/or have you used tobacco products? **Yes No Past**
Type: Cigarettes Cigars Pipes Snuff Chew Dip
How many packs per day? **.25 .50 1 2 3** How many years have you/ or did you smoke? _____
What year did you stop? _____ Have you tried to quit? **Yes No**
Do you use alcohol? **Yes No Former** If former, what year did you quit? _____
Type: Beer, Wine, Hard Liquor **Frequency**? Daily Weekly Monthly Occasionally Rarely Socially
Amount when you have a drink? (1 drink, 2 drinks, 3 drinks..?) _____ Last drink? (last night, last week, last month, last year..?)_____
Caffeine Use? **Yes No** **Type:** Coffee, Soda, Tea, Energy Drinks, Chocolate, Tablets
Amount Daily: _____Cups _____ OZ
Do you have HIV risk factors? **Yes No** Other drug use? **Yes No**

ENVIRONMENTAL HISTORY:

How long have you lived in New Mexico? _____Year(s)/Month(s)
Do your symptoms seem to increase at work? **Yes No** Hobbies? _____
Type of Residence you live in? **Apartment Condo House Mobile Home**
Age of Residence/Building? _____Year(s)/Month(s)
How long have you lived at your current residence? _____Year(s)/Month(s)
Do you have a yard or acres? **Yard Acres** If acres, how many? _____ Are you near open fields? **Yes No**
Are there smokers in the home? **Yes No** If yes, who?
Self ___ Spouse ___ Father ____ Mother ___ Other___
Type of bedding you sleep on? Box Spring _____ Waterbed _____ Foam _____ Crib_____ Allergy covered_____
Do you have any down bedding? Pillow____ Comforter ____ Feather Bed ____ Blanket ____
Bedroom Environment: Carpeted? Yes No **Blinds Drapes Stuffed Animals House Plants Books**
Types of flooring throughout the residence: Carpeted___ Hardwood ___ Tile ___ Large area rugs ___
Vacuum: Regular HEPA Central
Any damp, moldy areas of the house? **Yes No** If so, where?
Infestation with: Mice Rats Cockroaches Other_____
Animals in the home? **Yes No**
(Example if you have 2 dogs and 1 cat, under type list dogs, how many 2 and the put the oldest of the two and if kept inside and in your room, under the 2nd section put type cat, how many 1 and the age and so forth)
Type: How Many: How old is the oldest?
Kept inside **Yes No** Do they go in your room? **Yes No**
Type: How Many: How old is the oldest?
Kept inside **Yes No** Do they go in your room? **Yes No**

MEDICATION LIST

Please list below **ALL medications that you take for any condition; include herbs and vitamins. **

Name of Medication	Strength or Dose	How Many per Day/Week	Reason for Medication

ALLERGIES: Medication/Food

NO KNOWN DRUG/FOOD ALLERGIES _____

Name of Medication, Drug, Dye, or Food	Type of Reaction/Intolerance	Severity (Mild, Mild/Moderate, Moderate/Severe, Severe)

REVIEW OF SYSTEMS

Please indicate if you have had any of the following in the last 30 days?

	Yes	No		Yes	No
Fever	___	___	Vomiting	___	___
Chills	___	___	Diarrhea	___	___
Night Sweats	___	___	Constipation	___	___
Appetite Loss	___	___	Heartburn	___	___
Weight Loss	___	___	Indigestion	___	___
Weight Gain	___	___	Bloating	___	___
Fatigue	___	___	Abdominal Pain	___	___
Hives	___	___	Muscle Pain	___	___
Rash	___	___	Muscle Cramps	___	___
Itching	___	___	Muscle Weakness	___	___
Swelling/Angioedema	___	___	Joint Pain	___	___
Vision Changes	___	___	Joint Stiffness	___	___
Hearing Changes	___	___	Joint Swelling	___	___
Itchy/Watery/Burning Eyes	___	___	Joint Redness	___	___
Facial Pressure/Pain	___	___	Headaches	___	___
Nasal Congestion	___	___	Dizziness	___	___
Post-Nasal Drainage	___	___	Numbness	___	___
Runny Nose	___	___	Tingling	___	___

Sneezing	___	___	Painful fingertips	___	___
Decreased sense of smell	___	___	Anxiety	___	___
Swollen Glands	___	___	Depression	___	___
Cough	___	___	Mood Changes	___	___
Shortness of Breath	___	___	Change in Sleep Pattern	___	___
Wheezing	___	___	Appetite Changes	___	___
Hemoptysis (Coughing Blood)	___	___	Cold Intolerance	___	___
Decreased Exercise Tolerance	___	___	Heat Intolerance	___	___
Snoring	___	___	Excessive Thirst	___	___
Chest Pain	___	___	Excessive Urination	___	___
Palpitations (Heart Pounding)	___	___	Abnormal Bleeding	___	___
Swollen Ankles	___	___	Easy Bruising	___	___
Difficulty Swallowing	___	___	Epistaxis (Bloody Nose)	___	___
Nausea	___	___	Enlarged Lymph Nodes	___	___

General:

Have you had the pneumonia vaccine shot (Pneumovax)? Yes No
Do you normally get the flu vaccine shot? Yes No
How many times in the last year have you had to take oral or injected steroids? _____
Are there any family situations that make you or your child's care more difficult? _____

1. **ALLERGY:** (Please circle answers.)
   Do you have allergies or hay fever? **Yes No Don't Know Seasonal**
   Have you ever been tested for allergies? **Yes No Don't Know**
   What type of testing? **Skin Blood (RAST)**
   Did you get allergy shots? **Yes No** For how long? When?
   Were they helpful? **Yes No**
   Do you have a history of the following: **Food/ Latex/ Insect Stings/ Dyes/ Antibiotics/ Injections?**

2. **SINUS:**
   Do you have a history of sinus problems? Yes No Color of nasal drainage today? _____
   How many times have you been treated for a sinus infection with antibiotics in the last year? _____
   Have you ever had sinus or nasal surgery? Yes No If yes, when? _____
   Did the surgery help? **Yes No**

3. **ASTHMA:**
   Have you ever been diagnosed with asthma? Yes No If yes, when did it start? _____
   Have you ever been to the emergency room because of your asthma? Yes No How often? _____
   Have you ever had to stay overnight in the hospital for your asthma? Yes No How often? _____
   Have you ever missed school or work due to your asthma? Yes No How often in the last year? _____

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the ***Notice of Privacy Practices***.

Patient Name: «PName» DOB: «PDOB» Account Number: «PNumber»

Parent/Legal Guardian: _____ (PRINT)

Signature: _____ Date: _____

Please initial and check or complete blanks for elected permission:

_____ I give permission for Advanced Allergy Associates of New Mexico to leave detailed messages on my ____home and/or ____ cell phone. (check one or both)

_____ I give permission for Advanced Allergy Associates of New Mexico to contact me via email at:

_____.

_____ I give permission for Advanced Allergy Associates of New Mexico to text message me at cell phone number: _____.

_____ I give permission for Advanced Allergy Associates of New Mexico to speak to:

_____, my _____ regarding:
(Name) (Relationship)

_____My Medical Treatment and/or _____My Financial Information (check one or both)