TLC Allergy & Asthma Associates, Inc.
OTTO LIAO, MD
American Board of Allergy and Immunology

Practice Limited to Allergy
Tel: (714) 838-2617 or (949) 269-6911

Date: _____

Dear _____,

This is to confirm your appointment on _____at _____ at our office in:

1076 E. 1st St. Suite B Tustin, CA 92780	25401 Cabot Rd. Suite 101 Laguna Hills, CA 92653	19582 Beach Blvd. Suite 314 Huntington Bch, CA 92648

Please take a moment to complete the enclosed medical and personal information sheets, making sure to fill out all pages completely **before the appointment**. You may be asked to reschedule your appointment if forms are incomplete. Please return these forms, along with a **copy of your insurance and identification card**. **Copayments are due at the time of service. If you have a high deductible insurance plan and your deductible has not been met, we will ask to collect your payment at the time of service.**

During your first appointment, a medical history and pertinent physical examination will be done. If allergy testing is indicated, skin testing may be ordered and scheduled. Unfortunately, many insurances do not pay for two services done on the same day (office visit and testing) so it is our office policy to separate testing and office visits. If testing must be done on the same day, an advance beneficiary notice will need to be completed. It is also our office policy that all testing and lab results will be reviewed directly with the physician in the office in person.

Many of our patients are very sensitive to perfumes, strong odors, and foods. Therefore, please refrain from using fragrances on the day of your visit and do not bring any food items into the office waiting room. Minors less than 18 years of age must be accompanied by a legal guardian or legal representative. A 3rd party authorization is available on our website.

We look forward to seeing you. **If you are unable to keep your scheduled appointment for any reason, it is important to notify us at least 48 hours prior to your appointment. There is a $35 fee for any missed appointments if our office is not notified.** For more office information you may see our website at: *www.TLCAllergy.com* or call the phone numbers above.

PATIENT INFORMATION

Last Name:	Age:	Date of Birth:
First Name: Gender: ☐**M** ☐ **F**		Ethnicity:
Address:		Home Phone:
City, State, Zip:		Cell Phone:
Employer**:** Employer Address:		Email:

RESPONSIBLE PARTY

Same as above? ☐ Yes ☐ No	Patient Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Last Name:	Gender: ☐ **M** ☐ **F** Marital Status: ☐ **S** ☐ **M** ☐ **D** ☐ **W**
First Name:	Date of Birth:
Address:	Driver's License:
City, State, Zip:	Social Security #:
Employer**:** Employer Address:	Home Phone: Cell Phone:

INSURANCE INFORMATION

Primary Insurance:	Policy/Subscriber:
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:
Secondary Insurance:	Policy Subscriber:
Address:	Insured Policy ID:
City, State, Zip:	Group Number:
Plan Phone:	Date of Birth:
Effective Dates:	Patient Relationship to Subscriber:

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/Legal Guardian Name:	Emergency Contact:
Address(if different than patient):	Patient Relationship: Permission to share medical information: ☐ Yes ☐ No
Home and Cell Phone:	Home and Cell Phone:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

The undersigned agrees, whether he signs as agent or as a patient, that in consideration of services to be rendered (e.g. skin testing, office visit etc.) by TLC Allergy and Asthma Associates, Inc., to the patient named above, he hereby obligates himself, assumes financial responsibility, and agrees to pay upon request to provider all charges for such services incurred by said patient. Should the account be referred to an attorney/collection agency for collection, the undersigned shall pay all responsible attorney fees and collection expenses. The undersigned understands that all bills are payable upon presentation and that she/he, not the insurance company, is responsible for the payment of the services. This office will file and collect from Insurance when insurance benefits are present. I hereby authorize TLC Allergy and Asthma Associates, Inc. to use "Signature on File" in lieu of an original signature for all medical claims submitted for services rendered on above patient.

X_____ Date:_____

Signature

OFFICE POLICIES

PRIVACY POLICY

May we leave a message on your **voicemail** at (home, work, or cell) or **text message*** regarding:

- Normal lab results? ☐ Yes ☐ No
- Your appointments? ☐ Yes ☐ No
- Your insurance or billing? ☐ Yes ☐ No

*Standard text messaging charges may apply.

Please name any other people with whom we may discuss or leave messages with regarding appointment, lab, or billing. If you do not wish to have information left with anyone but yourself, please check the box.

☐ Do not leave information with anyone else.

_____relationship_____

_____relationship_____

FINANCIAL POLICY

Payment is expected at the time of service by credit card, cash, or check. Patients are responsible for the appropriate deductible and co-insurance and for providing the correct insurance information for billing to insurance carriers. **Accounts that are past due more than 120 days are subject to being sent to a collection agency and may impact your credit score.** All fees including, but not limited to, collection fees, attorney fees, and court fees incurred shall become your responsibility in addition to the balance due this office. There is a **$35.00 service fee** for failed appointments that are not cancelled or rescheduled at least 48 hours in advance of your scheduled appointment. There is a **$25.00 service fee** on all returned checks.

MINOR PATIENTS

Minors less than 18 years of age must be accompanied by a legal guardian or legal representative. A 3rd party authorization is available of our website.

TESTING RESULTS

All testing results (skin testing, lung function testing, blood work, radiology tests) will be reviewed in the office with the physician in-person. Results will not be discussed via phone or email. A copy of your results will be given to you in the office in person. If you wish to have a copy mailed to you without discussion with the physician, a liability wavier and official records release form must be completed. A records fee may apply.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE TERMS OF THESE POLICIES.

_____ _____

Printed Name of Patient Printed Name of Legal Guardian

_____ _____

Patient Signature (or Legal Guardian) Date Signed

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To be completed by patient or parent.

Describe in your own words the reason for this visit:

_____
_____
_____

Nasal/Throat Symptoms

☐ nasal congestion
☐ nasal discharge- clear, yellow, green
☐ post nasal drip/throat irritation
☐ hoarseness/change of voice
☐ throat tightening/difficulty swallowing
☐ nasal itchiness
☐ frequent nose blowing
☐ sneezing
☐ loss of smell/taste

Chest Symptoms

☐ cough
☐ wheezing
☐ shortness of breath
☐ chest tightness
☐ waking up at night
☐ phlem/sputum
☐ difficulty with exercise
☐ used an inhaler medicine in the past
☐ severe episodes in last year
☐ emergency room visits
☐ hospitalizations

Sinus Symptoms

☐ frequent sinus infections
☐ facial pain/pressure/congestion
☐ tooth pain
☐ headaches
☐ bad breath

Eye Symptoms

☐ itchiness, redness, puffiness
☐ watery discharge
☐ eyelid irritation
☐ dark circles under eyes

Ear Symptoms

☐ frequent ear infections/fluid
☐ itching/popping/pain
☐ ringing/decreased hearing

Skin symptoms

☐ itchiness
☐ hives
☐ eczema/rash
☐ areas of swelling

WHAT MAKES YOUR SYMPTOMS WORSE?

☐ pollens (grass, weeds, trees)	☐ viral infections/colds	☐ dust	☐ latex
☐ animals (cat, dog, horse)	☐ mold/mildew	☐ exercise	☐ smoke
☐ weather changes	☐ Santa Ana winds	☐ stress	☐ strong odors
☐ emotions/laughter/crying	☐ cold air/humidity	☐ perfumes/chemicals	

WHICH SEASONS DO YOU HAVE SYMPTOMS?

☐ SPRING ☐ SUMMER ☐ FALL ☐ WINTER ☐ YEAR-ROUND

Name: _____ Date_____

Current Medications: Please list all medications that you are currently taking, including over-the-counter medications (**attach additional sheet if necessary**).

	Medication	Prescribed By	Date Started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Previous Medications: Please list any therapies previously tried for your problem.

	Medication	Date Stopped	Reason For Stopping
1.			
2.			
3.			
4.			
5.			

Please list all hospitalizations (including year and reason)

1.
2.
3.

Medical History:

1. Have you ever had nasal or sinus surgery? ☐ No ☐ Yes date_____
2. Have you had a tonsillectomy or adenoidectomy? ☐ No ☐ Yes date_____
3. Have you had ear tubes? ☐ No ☐ Yes date_____
4. Have you ever been tested for allergies? ☐ No ☐ Yes date_____
   If so, did you have skin tests or blood tests? ☐ Skin ☐ Blood
5. Have you ever had allergy injections? ☐ No ☐ Yes
   If so, please give dates and location: _____
   Did they help? ☐ No ☐ Yes
6. Any chest x-rays/sinus x-rays/CT scans? ☐ No ☐ Yes Date_____
   Results: ☐ Normal ☐ Abnormal_____
7. List all known drug allergies: _____
8. List all known food allergies: _____
9. Have you ever had an allergic reaction to bee stings, latex or aspirin? ☐ No ☐ Yes
   Describe: _____

Name: _____ Date_____

Check any previous or current medical conditions that you may have below.

☐ Eye Diseases (Glaucoma)	☐ Nasal Polyps	☐ Emphysema
☐ Croup	☐ Leg Swelling	☐ Sleep Apnea
☐ High Blood Pressure	☐ Stroke	☐ Mitral Valve Prolapse
☐ Heartburn or Acid Reflux	☐ Ulcers	☐ Prostate Problems
☐ Arthritis/Joint pains	☐ Migraines/Headaches	☐ Seizures/Blackouts
☐ Depression	☐ Chronic Fatigue	☐ Diabetes
☐ Thyroid Disease	☐ Myocardial Infarct/Heart Attack/Heart Surgery	

☐Other: _____

For children younger than 15 years old, complete the following:

1. Birth Weight: _____ ☐ Full term ☐ Premature_____
2. Were there any complications following delivery? ☐ Yes ☐ No
   Explain: _____
3. Has growth and development been normal? ☐ Yes ☐ No
   Explain: _____
4. Are immunizations up to date? ☐ Yes ☐ No
5. Does your child attend daycare or preschool? ☐ Yes ☐ No
   Age started_____

Family History

	AGES	ASTHMA	NASAL ALLERGIES	SKIN ALLERGY	OTHER
Father	_____	☐	☐	☐	☐ _____
Mother	_____	☐	☐	☐	☐ _____
Brothers	_____	☐	☐	☐	☐ _____
Sisters	_____	☐	☐	☐	☐ _____
Children	_____	☐	☐	☐	☐ _____

Name: _____ Date_____

Social History

Current Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education: Grade in school: _____ ☐ College ☐ Post-grad

Hobbies/sports: _____

Smoking History: ☐ Never ☐ Previous ☐ Current _____packs/day for _____yrs

Environmental History: (Please check the appropriate boxes.)

Home: ☐ House ☐ Apartment/Condo ☐ Campus/School housing

How long have you been living there: _____ #Bedrooms_____ #People: _____

Pets: ☐None ☐Cat ☐Dog ☐Birds ☐Hamster ☐ Rabbit ☐Horses ☐Other_____

Smokers: ☐None ☐Indoors By: _____ ☐Outdoors By: _____

Heat: ☐ Central ☐ Radiator ☐ Window Air conditioning: ☐Central ☐Window

Environmental controls: ☐ Air purifier ☐ Dust mite bed covers

Pillows/blankets: ☐Feather ☐ Non-feather Bed: ☐ Mattress ☐ Memory foam

Flooring: ☐ Hardwood ☐ Carpet ☐ Tile ☐ Vinyl/Laminate ☐Other: _____

Evidence of mold/water damage: ☐ No ☐ Yes

Current physicians seen:

	Name	Specialty	Date Last Seen
1.		**Primary care physician**	
2.			
3.			
4.			
5.			

Pharmacy (Name, phone): _____

Address:_____

_____

Whom may we thank for referring you?

- ☐ Physician Office Name: _____
- ☐ Relative or Friend Name: _____
- ☐ Insurance Provider Directory
- ☐ Other: _____

Name: _____ Date_____

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