

TLC Allergy & Asthma Associates, Inc.

OTTO LIAO, MD

American Board of Internal Medicine
American Board of Pediatrics
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:

1101 E. Bryan Ave.
Suite B
Tustin, CA 92780

25401 Cabot Rd.
Suite 101
Laguna Hills, CA 92653

18800 Main St.
Suite 107
Huntington Bch, CA 92648

800 Corporate Dr.
Suite 100
Ladera Ranch, CA 92694

Please take a moment to complete the enclosed medical and personal information sheets, making sure to fill out all pages **before the appointment**. This will greatly enhance our ability to have quality time together in the office. Please bring these forms, along with an insurance identification card at the time of your first visit.

During your first appointment, a medical history and pertinent physical examination will be done. This may take up to **one hour**, so please allow sufficient time. Ordinarily, no allergy testing is done at the first visit. If allergy testing is required, the appropriate appointments will be made at the conclusion of your initial consultation.

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.

Appointment schedules are generally closely followed. You will find that we are concerned with your time as well as ours. 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 24 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.

Sincerely,

Otto Liao, MD

PATIENT INFORMATION

Last Name:	Age:	Date of Birth:
First Name:	Gender: M F	Driver's License:
Address:	Social Security #:	
City, State, Zip:	Home Phone:	
Employer:	Work Phone:	Cell Phone:
Employer Address:	Email:	

RESPONSIBLE PARTY

Same as above? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Relationship to Guarantor: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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:	Work Phone:
Employer Address:	Home Phone:
	Cell Phone/Email:

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):	Address(if different than patient):
	Patient relationship to Contact:
Parent Home/Work Phone:	Contact Home/Work 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

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Notice Regarding Privacy of Personal Health Information

To our patients. This notice is regarding how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our practice is dedicated to maintaining the privacy of your health information. A full copy of this HIPAA policy is available to you for review off of our website at www.TLCAllergy.com or in the office.

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

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

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.

None. Do not leave information with anyone else.

_____relationship_____

_____relationship_____

Should you wish to cancel any of the above authorizations in the future, you must notify this office in writing. Thank you.

I, the patient or representative signed below, acknowledge that I have been given the opportunity to read the Notice of Privacy Practices available online at www.TLCAllergy.com or in the office. I have also been given the opportunity to ask questions about personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature of responsible party: _____ Date _____

Print name: _____

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

WHAT MAKES YOUR SYMPTOMS WORSE?

- | | | | |
|--------------------------------------------------------|-------------------------------------------------|---------------------------------------------|---------------------------------------|
| <input type="checkbox"/> pollens (grass, weeds, trees) | <input type="checkbox"/> viral infections/colds | <input type="checkbox"/> dust | <input type="checkbox"/> latex |
| <input type="checkbox"/> animals (cat, dog, horse) | <input type="checkbox"/> mold/mildew | <input type="checkbox"/> exercise | <input type="checkbox"/> smoke |
| <input type="checkbox"/> weather changes | <input type="checkbox"/> Santa Ana winds | <input type="checkbox"/> stress | <input type="checkbox"/> strong odors |
| <input type="checkbox"/> emotions/laughter/crying | <input type="checkbox"/> cold air/humidity | <input type="checkbox"/> perfumes/chemicals | |

WHICH SEASONS DO YOU HAVE SYMPTOMS?

- SPRING SUMMER FALL WINTER YEAR-ROUND

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

Name: _____

Date _____

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

	<u>Medication</u>	<u>Prescribed By</u>	<u>Date Started</u>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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

	<u>Medication</u>	<u>Date Stopped</u>	<u>Reason For Stopping</u>
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.

- | | | |
|----------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Eye Diseases (Glaucoma) | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Heart Burn or Acid Reflux | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Arthritis/Joint pains | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Seizures/Blackouts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Myocardial Infarct/Heart Attack/Heart Surgery | |
| <input type="checkbox"/> Other: _____ | | |

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

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

Family History

	<u>AGES</u>	<u>ASTHMA</u>	<u>NASAL ALLERGIES</u>	<u>SKIN ALLERGY</u>	<u>OTHER</u>
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Brothers	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Sisters	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Children	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

Name: _____

Date _____

Social History

Current Occupation: _____

Marital Status: **S M D W**

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 Dormitory

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

Pets: Cat Dog Birds Hamster Rabbit Horses Other_____

Smokers: None Indoors By:_____ Outdoors By:_____

Heat: Central Radiator

Air conditioning: Central Window

Pillows/blankets: Feather Non-feather Bed: Mattress Waterbed

Flooring: Hardwood Carpet Tile Other:_____

Evidence of mold/water damage: No Yes

Current physicians seen:

	<u>Name</u>	<u>Specialty</u>	<u>Date Last Seen</u>
1.		Primary care physician	
2.			
3.			
4.			
5.			

Whom may we thank for referring you?

Physician Office Name:_____

Relative or Friend Name:_____

Insurance Provider Directory

Advertisement:_____

Other:_____

Name: _____

Date _____