Baz Allergy, Asthma & Sinus Center

7471 N. Fresno St. Fresno, CA 93720
Phone: (559) 436-4500 Fax: (559) 261-1526

Thank you for choosing our practice for your asthma and allergy needs. We are committed to the success of your treatment and care. We have seven offices to serve the needs of our patients.
We have scheduled your appointment in our ________________office on ___/___/___at___:___am/pm
If you are unable to keep this appointment, please call to reschedule within 24 hours prior to the appointment.

- **FRESNO** 7471 N. Fresno Street, Fresno CA 93720 Phone: (559) 436-4500
- **NW FRESNO** 7005 N. Milburn Suite 101, Fresno CA 93722 Phone: (559) 275-1400
- **S. FRESNO** 5043 E. Kings Canyon Ste 104, Fresno CA 93727 Phone: (559) 981-5040
- **N. CLOVIS** 2021 E. Herndon 2nd Floor, Clovis CA 93611 Phone: (559) 472-3116
- **S. CLOVIS** 1420 Shaw Ave. #105, Clovis CA 93612 Phone: (559) 325-9990
- **MADERA** 2311 W. Cleveland, Suite 1, Madera CA 93637 Phone: (559) 674-0075
- **HANFORD** 1560 W. Lacey Blvd. Suite 103, Hanford CA 93230 Phone: (559) 582-8500
- **VISALIA** 220 South Akers St. 1st Floor, Visalia, Ca 93291 Phone: (559) 713-1600

WHEN PAYMENT IS DUE :
Charges not covered by your insurance are due at the time of service this includes any **CO-PAYS**, **CO-INSURANCES** and **DEDUCTIBLES**. Co-payments will not be billed and must be paid at the time of service. **PAYMENT IS DUE WHEN SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.** We accept cash, checks, Visa, MasterCard and Debit cards. A service fee of $50.00 will be added on any returned checks.

YOUR INSURANCE COVERAGE :
We attempt to alleviate as much of the "insurance hassle" as possible for our patients and as a courtesy we will call your insurance company to verify your coverage benefits prior to your visit. We encourage you to call your insurance company and review your benefit coverage. The benefits quoted to us are not a guarantee of payment. After the claim is filed any non-covered services become the responsibility of the patient. If you have any questions regarding your financial responsibilities at our office, please do not hesitate to ask our billing department, prior to being seen or any procedures provided.
In order to save you time and avoid inconvenience, we anticipate allergy testing may be involved during this visit. Please be aware that your first visit may take up to two to three hours. If this appointment is not for a child we strongly suggest that children not accompany you. Allergy testing requires the patient to be perfectly still and we have found that patients with children are unable to do so. **DO NOT TAKE ANTIHISTAMINES 4 Days PRIOR TO YOUR VISIT.** Enclosed you will find a list of medications to avoid, if taken we will be unable to do any allergy testing. Asthma medication, as well as other medications may be continued. **Please bring all medications (or a complete list) you are currently taking to your appointment.**

MINOR PATIENTS: The parent or guardian accompanying a minor is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied.
To expedite your visit we have enclosed forms, which will need to be completed by you. Please bring the completed forms and your insurance card with you to your appointment. To help the doctor provide you with the best possible diagnosis of your condition the patient's history needs to be completed thoroughly.
If you have any questions regarding these instructions, or if you have any concerns, do not hesitate to call.

We look forward to seeing you,
BAZ ALLERGY, ASTHMA & SINUS CENTER

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Phone: (559) 436-4500 Fax: (559) 261-1526

FRESNO **DATE:________________________**

Dear New Patient: **We would appreciate it if you would fill out the following survey for us:**

Patient Name (optional)____

How did you hear about us? (Choose all that apply)

Doctor (Name) ____

Friend or Relative (Name)____________________________________
Address_______________________________________

Newspaper: Fresno Bee Clovis Unified School District Newspaper
Other: ___________________

Phone Book: Pacific Bell Valley Yellow Pages
Clovis Western Directories Other: _________________

Television:			
	Channel 26	Ad	News/Pollen Count
	Channel 47	Ad	News/Pollen Count
	Channel 30	Ad	News/Pollen Count
	Channel 24	Ad	News/Pollen Count

Radio: KMJ
ESPN Radio 1430 Other Channel:_________________

Saw Building Sign

Internet

Do you use the Internet?	Yes	No
If yes, have you ever used it to look up medical information?	Yes	No
Have you ever used the Internet to look up any allergy, asthma or sinus related information?	Yes	No

Thank you very much for filling out this survey.
Do you have any other suggestions or recommendations for us to improve our services?

____

____

Thank you,
M.N. Baz, M.D.

ANTIHISTAMINES TO BE STOPPED FOR POSSIBLE ALLERGY TESTING:

Stop **FOUR** days before testing:

Actagen
Actifed
Acrivastine
Allegra (any)
Allerfrin
Allerx
Antivert
Atarax
Benedryl
Bromphed
Brompheniramine
Cetirizine
Chlorpheniramine
Chlor-trimeton
Clarinex
Claritin (any)
Clemastine
Cyroheptadine
Deconamine
Dimenhdrinate
Dramamine
Dimetane
Dimetapp
Diphenydramine
Drixoral
Duravent-DA
Fexofenadine
Histavent-LA
Histex
Hydroxyzine
Loratadine
Meclizine
Omnihist-LA
Ornade
Pediacare
Periactin
Phenergan
Poly-histine
Promethazine
Rondec
Rynatan
Ryna-12
Rynatuss
Semprex-D
Tanafed
Tavist
Triaminic
Triaminicol
Trinalin
Tripolidine
Tussi-12
Tussionex
Vistaril
Zyrtec (any)

NASAL SPRAYS:

Astelin
Azelastine

EYE DROPS:

Azelastine
Patanol
Olopatadine
Optivar
Zaditor

ALSO: Any medicine that has the words **SINUS, ALLERGY, "HIST" or HISTAMINE**

Please advise the patients the following: Many over the counter medications have allergy medicine in them (i.e. sinus, headache, sleep or cough medicines). These medications will need to be stopped 4 days prior to the visit as well. If you are not sure if the medicine you are taking contains an antihistamine, please call the office for advice. **DO NOT** stop any other medications for heart, liver, lung or other conditions. If for some reason you cannot stop the allergy mediations then don't. We will see you for the consultation and then appropriate testing can be done at a later date.

Baz Allergy, Asthma & Sinus Center

DO NOT TAKE ANY ANTIHISTAMINES, IF POSSIBLE, FOR 72 HOURS BEFORE YOUR FIRST VISIT. CONTINUE THE REST OF YOUR MEDICATIONS

Name: ______________________ **Age:** ____ **Sex: M / F** **Date:** __________

Occupation / Job Description: ______________________ **DOB:** __________

Address: ______________________ **Phone#** __________

Hobbies: ______________________

Family Doctor: ______________________ **Who Referred You Tou Our Office?:** ______________________

Doctor's Seen In The Past: ______________________

Primary Reason For Seeing Us Today? ☐ Allergies ☐ Asthma ☐ Sinusitis ☐ Headaches ☐ Cough ☐ Hives ☐ Eczema

Other:

Previous Allergy Evaluation:

Have You Ever Seen An Allergist? **Y / N** (Name? ______________________)

Have You Ever Had An Allergy Skin Testing? **Y / N**

Have You Ever Received Allergy Injections? **Y / N**

If YES, Were Injections Helpful? **Y / N**

Nose / Eyes: ☐ ALL YEAR ☐ SEASONAL

When Do You Have These Symptoms?

Check Symptoms	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Runny Nose												
Stuffy Nose												
Sneezing												
Post Nasal Drip												
Itchy Eyes/Nose												

Please Check All That Trigger Or Make Your Allergies Worse

Allergens				Irritants			
	Freshly Mowed Grass		Molds		Smoke		Fumes
	Dead Grass		House Dust		Perfumes		Windy Days
	Hay		Cats		Soaps		Cold Days
	Flowers		Dogs		Cosmetics		Damp Days
	Flower Pollens		Feathers		Cleaning products		Humidity
	Trees				Paint Fumes		Alcoholic Beverages
	Tree Pollens				Hair Spray		Spicy Foods
	Weeds				Outside Dirt		

Head: ☐ Headaches ☐ Facial / Sinus Pain

☐ Sinus X-rays Done? When: __________ Where: __________

Other Symptoms:

Ears: Popping Of Ears Ear Aches Ear Tubes

Other Symptoms:

DOCTOR'S USE ONLY (PLEASE DO NOT WRITE IN THIS AREA)

Historian?
☐ Patient ☐ Other __________

How Long?
☐ Perennial ☐ Seasonal
☐ Spring ☐ Summer
☐ Fall ☐ Winter
Severity: ☐ Mild ☐ Mod. ☐ Severe

Frequency: ______ x wk / month

☐ Nausea ☐ Vomiting
☐ Diplopia ☐ None

Chest: ❑ ALL YEAR ❑ SEASONAL

❑ Do You Wheeze? Y / N
- ❑ When You Get A Cold?
- ❑ When Exposed To Cold Air?
- ❑ At Night? ❑ When Exercising?

❑ Do You Cough? Y / N
- ❑ At Night? ❑ When Exercising?
- ❑ When Exposed To Cold Air?

❑ Productive Cough? Y / N
- Color? ❑ Clear ❑ Yellow ❑ Green ❑ Brown
- How Long Have You Had This Cough? ____________________
- How Many Months Of The Year Do You Have This Productive Cough? ____________________

When Do You Have These Symptoms?

Check Symptoms		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Wheezing												
	Cough												

❑ Chest X-rays Done? When? ________________ Where? ________________

Have You Ever Been Diagnosed With Chronic Bronchitis? Y / N

Have You Ever Been Diagnosed With Emphysema? Y / N

Skin Problems: ❑ None

❑ Eczema? How Long? ______________

❑ Hives? How Long? ______________

❑ Any Problems with Rubber or Latex Materials Y / N

❑ Other Skin Diseases or Symptoms? ________________________________

Food Allergy / Stomach Problems:

❑ Gas? ❑ Cramps? ❑ Diarrhea? ❑ Other? ____________________

Which Food(s) and What Kind Of Reactions Do You Have? ____________________

Insect Allergy:

Have you ever had an allergic reaction to an insect bite? Y / N

If YES, Please Check All Insects That Have Triggered An Allergic Reaction

❑ Honey Bee ❑ Yellow Jacket ❑ White Faced Hornet

❑ Wasp ❑ Kissing Bug ❑ Other Insects

Environmental:

	INSIDE	OUTSIDE	SLEEPS IN BEDROOM
CATS:			
DOGS:			
OTHER:			

Past Medical / Surgical History:

Please List Illnesses / Surgeries You Have Had In The Past

DOCTOR'S USE ONLY

How Long?

❑ Perennial ❑ Seasonal

❑ Spring ❑ Summer ❑ Fall ❑ Winter

❑ Cough ❑ Wheezing ❑ Chest Tightness

Nocturnal Symptoms? Y / N

Frequency: _____ x day / wk / month

Beta Agonist Use?

Frequency: _____ x day / wk / month

Use in last ______ day(s) / wk(s)

Any Hospitalizations for Asthma? Y / N

If yes, when was the last time?

Medications:

List All Medications, Including Over The Counter Medicine, Birth Control, Vitamin Supplements, and Herbal Medicines.
Please Include Dosage and How Many Times A Day You Take It.

Drug Allergies:

Are You Allergic To Any Drug(s)? **Y / N**
If YES, Please List the Drug(s) And Type Of Reaction?

Social History:

Do You Smoke? **Y / N** If YES, For How Long? ______________
How Much? ______________________

Have You Quit Smoking? **Y / N** If YES, When? ______________________
Does Anybody Smoke In The House? **Y / N** Who? ______________________
Do You Drink Alcohol? **Y / N** How Much? ______________________
Do You Use Any Other Recreational Drugs? Please List ______________________
Any Animals or Smokers at Baby Sitters, Grandparents, or Work? **Y / N**
(Please List)

Birth History:

Please List Any Abnormal Conditions / Problems at Birth Or As An Infant:

Please Check All That Apply To You

Childhood History:

- ☐ Frequent Colds?
- ☐ Frequent Sinusitis?
- ☐ Frequent Sore Throats?
- ☐ Frequent Wheezing?
- ☐ Frequent Bronchitis?
- ☐ Frequent Ear Infections?
- ☐ Frequent Headaches?
- ☐ Frequent Coughing?
- ☐ Excessive Fatigue?

Any Other Conditions? (Please List)

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Family History:

Please Check If Any That Apply To Family Members

	Hay Fever	Asthma	Eczema	Sinus Problems	Other Allergies
Brother(s)					
Sister(s)					
Mother					
Father					
Maternal Gr. Parents					
Paternal Gr. Parents					

Please List Any Family Diseases:

Female Patients:

Are You Taking Birth Control Pills? **Y / N**

Do You Have Regular Menses? **Y / N**

If YES, When Was Your Last Menstruation? ____________________

Are You Pregnant? **Y / N**

Housing:

Please Check If Any That Apply To You

Where Do You Live?

- ☐ Apartment
- ☐ House
- ☐ Rural
- ☐ Urban
- ☐ Mountain

Describe Your Work Place Environment?

Do You Use A Blanket? **Y / N** How Often Is It Washed? ____________

Please Check If You Have These Things In Your Residence

- ☐ Feather Pillows
- ☐ Feather Comforters
- ☐ Stuffed Toys
- ☐ Carpeting
- ☐ Humidifier
- ☐ Dehumidifier
- ☐ Indoor Plants
- ☐ Hepa Filter System
- ☐ Book Cases
- ☐ Central Air / Heating
- ☐ Swamp Cooler
- ☐ Wood Burning Stove

Is There Anything Near Your Home That Might Pollute The Air or Water **Y / N**

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Any Children? **Y / N** If YES, How many? ____________

Please List Their Names:

DOCTOR'S USE ONLY

Form Completed By Whom? ____________________ **Relationship:** ____________

What Do You Expected From Your Allergist? ____________________

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☐7005 N. Milburn Suite 101, Fresno, CA 93722
Phone: (559) 275-1400 Fax: (559) 274-1487

☐2021 E. Herndon 2nd Floor, Clovis CA 93611
Phone: (559) 472-3116 Fax: (559) 324-8748

☐1420 Shaw Ave#105 Clovis, CA 93611
Phone: (559) 325-9990 Fax: (559) 797-0004

☐2311 W. Cleveland Ave. Ste.1, Madera, CA 93637
Phone: (559) 674-0075 Fax: (559) 673-6058

☐ 220 S. Akers St. Ste. A , Visalia CA 93291
Phone: (559) 713-1600 Fax: (559) 713-1602

☐1560 W. Lacey Blvd. #103, Hanford CA 93230
Phone: (559) 582-8500 Fax: (559) 584-9133

☐5043 E. Kings Canyon Ste 104, Fresno Ca 93727
Phone: (559) 981-5040 Fax: (559) 981-5647

FINANCIAL POLICY

Our continued participation in your health plan depends upon everyone fulfilling his/her obligation in accordance with the contracts. As a service to our patients, we call your insurance to get a description of benefits. This office is not responsible for incorrect benefit information given to us by your insurance carrier, or changes in coverage after verification date. A description of benefits is not a guarantee of coverage and cannot be relied on as such. In the event of non-payment by your insurance company the charges on your account will be your responsibility. Patients are responsible for all deductibles, co-payments, coinsurance and non-covered charges. Payment is due at the time service is rendered. We accept Visa, MasterCard, Discover, Personal Checks and Cash for your convenience. If you want to verify the insurance benefits quoted yourself, please call your insurance company.

PATIENT CONSENT: I hereby give consent for such medical treatment for myself or I am duly authorized by the patient and his/her general agent to consent for such treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize payment for medical benefits directly to the provider of the services rendered.

RELEASE OF INFORMATION: I hereby authorize the release of any medical information necessary to process any insurance claims.

Patient Signature:____**Date:**___________________

(If patient is under 18 parent or guardian must sign)

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Phone: (559) 436-4500 Fax: (559) 261-1526

1420 Shaw Avenue # 105, Clovis CA 93612
Phone: (559) 325-990 Fax: (559) 797-0004

1560 W. Lacey Blvd. #103, Hanford CA 93230
Phone: (559) 582-8500 Fax: (559) 584-9122

2311 W. Cleveland Ave., Madera CA 93637
Phone: (559) 674-0075 Fax: (559) 673-6058

40232 Junction Drive Oakhurst, CA 93644
Phone: (559) 642-2500 Fax: (559) 642-2888

205 S. West St. Suite D, Visalia CA 93291
Phone: (559) 713-1600 Fax: (559) 713-1602

2021 E. Herndon 2nd Floor, Clovis, CA 93611
Phone: (559) 292-8700 Fax: (559) 324-8748

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out Treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1.Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceeding; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

PRINT NAME_________________________________ **SIGNATURE**___________________________________

DATE_____________________

Patient Name:	Account Number:

MEDICAL INFORMATION RELEASE

This is to advise you that I have given authorization to Baz Allergy, Asthma & Sinus Center to provide any and all necessary information regarding my medical care to the following individuals below. This authorization is effective until terminated in writing.

Name (print)	Relationship to Patient
Name (print)	Relationship to Patient
Name (print)	Relationship to Patient

Signature of Patient ____________________ Date ____________

EMERGENCY PHONE NUMBERS

Name (print)	Work	Home	Cell	Relationship to Patient
Name (print)	Work	Home	Cell	Relationship to Patient
Name (print)	Work	Home	Cell	Relationship to Patient

Signature of Patient ____________________ Date ____________