ALLERGY & ASTHMA
CONSULTANTS OF MONTANA

MICHAEL C. DICELLO, MD
CINDY FEDDES, FNP

Date: _____

NEW PATIENT MEDICAL HISTORY

Please state the problem(s) or symptom(s) that bring you here today for consultation:

_____

_____

Which of the following appear to cause your allergy / asthma symptoms?
Animals: ☐Horse ☐ Cat ☐ Dog ☐ Cow ☐ Rabbit Other: _____

Odors: ☐ Christmas trees ☐ Detergents ☐ Soaps ☐ Tobacco smoke ☐ Cosmetics or perfumes ☐ Paint fumes

Other: _____

Pollen: ☐ Trees ☐ Weeds ☐ Grasses ☐ Molds

Other: ☐ Temperature changes ☐ Menses(period) ☐ Exertion ☐ Air Conditioning ☐ Infections ☐ Excitement
☐ Windy days ☐ Laughing ☐ Tension ☐ Fatigue ☐ Depression ☐ Pain relievers (ibuprofen or aspirin)

When did your symptoms begin? (please specify date)_____
When do your symptoms occur? (circle all that apply) Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Have you ever had an allergic reaction to any medication? ☐ Y ☐ N
If yes, what specifically happened?_____

Have you ever had an allergic reaction to any food? ☐ Y ☐ N
If yes, what specifically happened?_____

Have you ever had any insect sting or bite reaction? ☐ Y ☐ N
If yes, specify date_____ Symptoms: _____

Have you had any Emergency Room visits &/or hospitalizations for allergies or asthma in the past year? ☐ Y ☐ N
If yes, please describe: _____

_____

FAMILY MEDICAL HISTORY: (please check all that apply)

	Mother	Father	Siblings	Children	Aunts	Uncles	Grandparents
Hay Fever							
Asthma							
Eczema							
Other Lung Disease							

Are there any other conditions that occur in your family (for example, cystic fibrosis, recurrent hives or swelling, or lupus)?
_____

HAVE YOU EVER SEEN AN ALLERGIST PREVIOUSLY? ☐ **Y** ☐ **N**
If yes, who, when and where? _____

Were you diagnosed with allergies? ☐ Y ☐ N
If yes, what were the findings? _____

Have you ever been on immunotherapy (allergy shots) before? ☐ Y ☐ N
If yes, when and where? _____ Did it help? ☐ Y ☐ N
Did you have any severe reactions to the allergy shots? ☐ Y ☐ N
If yes, please explain: _____

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ENVIRONMENTAL / SOCIAL HISTORY

HOME general

Heating: ☐ forced air ☐ woodstove ☐ hot water ☐ electric ☐ kerosene ☐ other_____

Does anyone smoke inside the home? ☐ Y ☐ N Number of smokers: _____

Flooring in living area: ☐ carpeted ☐ non-carpeted ☐ mixed

Vacuum: ☐ regular ☐ central ☐ HEPA ☐ double thickness bags

Basement: ☐ none ☐ finished ☐ unfinished ☐ has flooded in past

Portable filter: ☐ none ☐ HEPA ☐ ionizer ☐ electrostatic

BEDROOM

Pillow: ☐ feather ☐ non-feather ☐ airtight cover

Mattress: ☐ innerspring ☐ waterbed ☐ other: _____

Comforter: ☐ feather ☐ non-feather ☐ other: _____

Air Conditioning: ☐ Y ☐ N

Humidifier: ☐ Y ☐ N

Overhead fan used: ☐ Y ☐ N

PETS ☐ Yes ☐ No If Yes, please complete the following:

	Outside	Inside	In bedroom
Cat(s)			
Dog(s)			
Other pets or animals in environment:			

Are there pets at daycare or school? ☐ Y ☐ N

FOR CHILDREN:

Attends daycare ☐ Y ☐ N # of days a week_____ Are there smokers at daycare/school? ☐ Y ☐ N

Immunizations up to date ☐ Y ☐ N

Had Chicken Pox vaccine ☐ Y ☐ N

Lives with both parents in the same home ☐ Y ☐ N

If No, are there any **smokers** in the secondary home? ☐ Y ☐ N Are there any **pets?** ☐ Y ☐ N

Frequency of visits to secondary home: _____

CURRENT MEDICATIONS

Please list all medications you are using, including any prescription drugs, over-the-counter medications, supplements, vitamins, pain relievers, and any medications taken "as needed." If you need additional space, please list medications on the back of this sheet.

MEDICATION	CURRENT DOSE	START DATE	DATE LAST USED	REASON FOR USE

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REVIEW OF SYSTEMS (please check any items that apply)

Constitutional
☐ good general health
☐ poor appetite
☐ recent weight gain or loss
☐ excessive tiredness
☐ recurrent fevers (temp = 101°)

Head
☐ headaches
☐ migraine headaches
how often? _____
☐ sinus disease/problems
☐ head injury

Eyes
☐ dry eyes
☐ wear contact lenses
☐ redness
☐ itching
☐ cataracts
☐ glaucoma

Mouth / Throat
☐ excess dryness of mouth
☐ hoarseness
☐ trouble swallowing
☐ excessive thirst and drinking
☐ itching of throat or mouth

Heart
☐ palpitation or pounding of heart
☐ angina/chest pain
☐ irregular heart beat
☐ heart murmur
☐ history of heart attack
☐ high blood pressure

Alcohol History
Average # of drinks/week _____

Gastrointestinal
☐ heartburn/acid indigestion
if yes, how often?_____
☐ wakes you from sleep
☐ taste heartburn in back of throat
☐ recurrent vomiting
☐ frequent diarrhea
☐ history of ulcer
☐ hiatal hernia
☐ history of hepatitis
☐ history of liver disease

Genitourinary
☐ kidney trouble
☐ frequent urination
☐ prostrate trouble/cancer

Musculoskeletal
☐ painful swelling of joints
☐ arthritis
☐ osteoporosis
☐ scoliosis/curvature of the spine

Ears
☐ frequent infections
☐ itching
☐ blockage
☐ hearing loss

Neurologic
☐ hyperactivity disorder/ADHD
☐ Parkinson's
☐ depression
☐ convulsions/epilepsy/seizures
☐ insomnia
☐ Multiple Sclerosis
☐ ever consulted a psychiatrist/psychologist
☐ mental illness

Blood/Lymphatic
☐ blood disorder
☐ anemia
☐ swollen lymph nodes
☐ history of
blood product transfusion

Endocrine
☐ thyroid problems
☐ diabetes

Skin
☐ hives
☐ eczema
☐ acne
☐ itchy/dry
☐ cancer
☐ psoriasis

Nose
☐ polyps
☐ congestion/runny nose
☐ bleeding
☐ sneezing
☐ itching
☐ loss of smell

If Female
☐ postmenopausal
☐ planning pregnancy
when?_____

Smoking History
☐ never smoked
☐ former smoker
___ packs a day for ___ years
☐ current smoker
___ packs a day for ___ years

Other Problems/Illness

_____

_____

MY SIGNATURE INDICATES THAT THIS MEDICAL HISTORY IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

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Date: _____

Patient Communication

Emergency Contact:

Name_____ Relationship to Patient:_____

Best phone:_____ ☐ Home ☐Cell ☐Work Alternate phone:_____ ☐ Home ☐Cell ☐Work

May we discuss the patient's medical care with this person? ☐Yes ☐ No

If the patient is a **minor** OR patient's **parents are financially responsible**:

Mother's name _____ Best phone:_____ ☐ Home ☐Cell ☐Work

Address (if different than patient) _____

_____

Father's name:_____ Best phone:_____ ☐ Home ☐Cell ☐Work

Address (if different than patient) _____

_____

May we discuss the patient's medical care with both parents? ☐Yes ☐ No

Allergy & Asthma Consultants of Montana may discuss information involving your care with:

Check this box and sign below if we may ONLY discuss your care with you: ☐ ☐

Please list anyone we may discuss your care with, including but not limited to, insurance policy holder, primary care doctor, etc.:

Name:	Relationship to patient:	Type of information: All	Sched/appt	Medical	Billing
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

Signature of patient or guardian: _____ Date: _____

Relationship to patient: _____

We will continue to rely on the information on this form when communicating with others involved in your care unless you request changes. To revoke this authorization, please submit a written request to Allergy & Asthma Consultants of Montana at your earliest convenience.

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GENERAL PRACTICE INFORMATION

We are a service oriented group of Board Certified Specialists in
Adult & Pediatric Asthma, Allergy & Immunology.

MISSION STATEMENT

Our mission is to serve our community by helping patients achieve their optimal health by providing exemplary, comprehensive treatment of allergies and asthma. We are guided by the values of compassion and respect for the dignity of every person, and know that in taking time to listen to our patients we can best provide an individually designed plan to meet the varied needs of each person. We are committed to educating our patients, as patient education is a central component of successful medical care.

OUR GOALS

- To assist patients so that their allergy and asthma symptoms do not limit their quality of life. We are committed to the idea that every child and adult should have the opportunity to live life aggressively, even with allergies or asthma.
- To carefully consider patients' concerns and think about them in their overall context, then offer multiple solutions. Patients should be able to choose a treatment plan that they understand and feel committed to complying with.
- For patients to feel comfortable asking our providers questions and feel confident when they leave that their questions were addressed and they understand the treatment options offered to them.
- For patients' primary care physicians to have their concerns addressed and be informed of their patients' treatment plans.
- To understand the patient's problems and offer creative treatment strategies that don't always involve medications. If medications are recommended, then we strive to minimize or optimize those medications when used.
- To educate patients that shots are just one of the choices in treatment. Immunotherapy may be an option for patients who meet the medical criteria and are educated and interested in pursuing that course of treatment.
- For the medical and office staff interactions with patients to be professional, helpful, and friendly.

OUR PRACTICE

- We request that you have a primary care doctor, as we do not hospitalize patients. **If you have an acute medical emergency that cannot wait, please call your primary care doctor or 911.**

- All minor patients (18 years and under) must be accompanied by their legal guardian for all appointments unless prior arrangements have been made with the office staff.

- We can refill prescriptions by phone or fax during regular working hours, 8:30am to 5:00pm Monday through Friday. Please allow 24 hours for your refill request to be filled. **We may request that you be seen in the office before we refill your medication. Asthma patients must be seen every 6 months and all other patients must be seen annually for medication management.**

- For more information please visit our website at **www.allergymontana.com**

We look forward to participating in your health care.

I have read the above information and all my questions and concerns have been satisfied.

Patient/Guardian Signature:_____ **Date:**_____

2055 North 22nd, Suite 1 — Bozeman, MT 59718 — P:406.582.1111 — F:406.582.1112

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FINANCIAL POLICIES

We require a copy of a photo ID and any insurance cards that are to be billed for services rendered.

- **PAYMENT—** Our office will attempt to verify your insurance benefits prior to or during your appointment so that we may collect based on your benefits. **Payment is expected at the time of your visit**. Payment will include any unmet deductible, co-insurance, co-pay amount, or non-covered charges from your insurance company. If charges exceed what you are able to pay, you may speak with the billing department at your first visit to establish a short term payment plan.

- **INSURANCE—** Our practice currently participates with Blue Cross/Blue Shield, Allegiance (including affiliated Cigna plans), New West, Pacific Source, United Healthcare, TriWest, Medicare, and Medicaid; although this may be subject to change. Our office will file all insurance claims. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.** Although, we may attempt to verify your insurance benefits, it is your responsibility to check with your insurer's member benefits department about your coverage prior to your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and are responsible for payment in full if your claim is rejected.

- **LATE CHARGES**—A finance charge of 8% annually will be applied to patient balances of 90 days or older. We offer short-term payment plans as well as other payment options to assist with large balances. Please reach out to our billing manager if you have any concerns about paying your balance in full to avoid late charges.

- **PAST DUE ACCOUNTS—** In the event your account is turned over to a collection agency, you will be responsible for all costs and fees associated with collection, including without limitation, attorney's fees.

- **RETURNED CHECKS**—will incur a $30.00 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.

- **MINOR PATIENTS (under the age of 18)** — The adult accompanying a minor is responsible for payment of the minor's account. If there is a financial arrangement with another adult, we need written authorization and mailing address for the financially responsible adult that he/she consents to payment of services for the minor.

- **ADULT PATIENTS (age18 and older)** — If another adult is financially responsible for you we will need written authorization, including a mailing address, for the person who is financially responsible for payment.

- **PAYMENT OPTIONS—** We accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE POLICIES

PATIENT/GUARDIAN SIGNATURE_____

Date_____

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NO SHOW/CANCELLATION POLICY

We ask that you provide our office with at least **24 hours advanced notice** of any appointment changes or cancellations. If you do not attend your scheduled appointment ("no show") or fail to provide us with 24 hours advanced notice, you will be responsible for a **$25.00 fee**. This is not an amount that will be billed to insurance and it must be paid prior to your next scheduled appointment.

We do not double book appointments in an effort to maximize the amount of time our providers can spend with our patients. When patients make late cancellations or do not show for scheduled appointments, it prevents us from seeing other patients who are waiting for an opening in the schedule. We kindly ask for notification so that we may attempt to place another patient in this appointment slot.

We understand that emergencies come up and cancellations or no shows can be due to extenuating circumstances. If you feel as though you fall into this category, please contact our billing department and we can evaluate this on a case by case basis.

Thank you for providing our office this courtesy. Your signature below indicates that you have read, understand, and agree to these policies.

_____ _____

Patient/Guardian Signature Date

2055 N 22nd, Suite #1 – Bozeman, MT 59718 – P. 406.582.1111 – F. 406.582.1112 – office@aacmt.com