Thank You ForVisiting

IHNA

Allergy & Asthma

Dr. Geeta Venkat

Dr. Jacquelyn Hunter

Dr. Chongjia Chen

www.ocallergycenter.com

949-481-9701

PLEASE FILL OUT THE FORMS AHEAD

HNA Allergy & Asthma

Assignment of Benefits
And Release of Information to Medicare

I request the payment of authorized Medicare benefits be made either to me or on my behalf to the physician(s) or supplier listed below for any services provided to me by that physician or supplier. I authorize any holder of medical information about me to release to the **Centers for Medicare and Medicaid Services** and its' agents, any information needed to determine benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other insurance coverage is listed on my claim form or electronic claim, my signature authorizes the release of information to the insurer shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and/or non-covered services. Deductible and co-insurance are based upon the charge determination of the Medicare carrier. This assignment is valid from today's date and remains in effect until I, the patient, revoke this agreement.

HNA Allergy & Asthma

Geeta Venkat, MD
Jacquelyn Hunter, MD
Chongjia Chen, MD

_____ _____

Signature of Patient **Date Signed**

_____

Medicare Number (Required)

HNA Allergy & Asthma

Patient Questionnaire

Name:_____ DOB: _____ Date:_____

	Mother	Father	Siblings				Children			
Age (if alive)										
Health(good/bad)										
Cancer										
Tuberculosis										
Diabetes										
Heart Issues										
Hypertension										
Stroke										
Epilepsy										
Nervous Breakdown										
Asthma, hives, hayfever										
Blood disease										
Age (at death)										
Cause of death										

Personal History

What is the #1 concern brininging you to an allergist?

Runny nose/ sinus congestion _____ **Eczema/Rash** _____

Cough/Asthma/Wheezing _____ **Drug Allergy** _____

Nasal Polyps_____ **Something Else** _____

Please list **ALL** medications/supplements you take:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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Sino-Nasal Outcome Test (SNOT 22)

Please circle the number that best describes your symptoms over the past **2 weeks.**

Use this scale to describe how bad the problem when it occurs →	No Problem	Very mild problem	Mild or slight Problem	Moderate problem	Severe problem	Worst the problem can be
Need to blow nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Runny Nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Post-Nasal drainage	0	1	2	3	4	5
Thick nasal discharge	0	1	2	3	4	5
Ear fullness	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear pain/pressure	0	1	2	3	4	5
Facial pain/pressure	0	1	2	3	4	5
Difficulty falling asleep	0	1	2	3	4	5
Waking up at night	0	1	2	3	4	5
Lack of a good night's sleep	0	1	2	3	4	5
Waking up tired	0	1	2	3	4	5
Fatigue during the day	0	1	2	3	4	5
Reduced productivity	0	1	2	3	4	5
Reduced concentration	0	1	2	3	4	5
Frustrated/restless/irritable	0	1	2	3	4	5
Sad	0	1	2	3	4	5
Embarrassed	0	1	2	3	4	5
Loss of smell/taste	0	1	2	3	4	5
Congestion/obstruction of nose	0	1	2	3	4	5

Reviewed by:_____Date Reviewed:_____

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Past Medical History: Please **check** what you have been diagnosed with

- ☐ Anesthesia Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Kidney disease
- ☐ Bleeding Disorders
- ☐ Cataracts
- ☐ Congestive Heart Failure
- ☐ Cancer: Type_____
- ☐ Diabetes: Type_____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Immune Suppression
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Reflux (GERD)
- ☐ Enlarged glands
- ☐ Irregular bowel movements

Please list any other medical conditions: _____

_____

_____

Please list all **Allergies** (i.e. medications, foods, household products, etc)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list **ALL** surgeries **AND** hospitalizations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list **ALL** diagnostic/radiological tests and **WHY** they were done:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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Nasal/Sinus Worksheet

Name:_____ DOB:_____ Date_____

Do you have nasal obstruction/blockage/congestion:

- □ Yes, which side is worse ❒ right ❒ left ❒ both
- □ No

Do you use nasal sprays?

- □ Never
- □ Currently name of spray_____
- □ In the past name of spray_____

How many sinus infections have you been treated for in the past year? _____

Have you has a recent CT or MRI of your head/sinuses?

- □ No
- □ Yes Date_____ Location _____

Please check all symptoms that apply

- □ Nasal drainage
- □ Decreased sense of smell
- □ Headache, location_____
- □ Postnasal drainage
- □ Facial ❒ pain ❒pressure ❒ fullness
- □ Sneezing
- □ Itchy eyes or nose
- □ Watery eyes or nose

Have you ever been tested for allergies? ❒ Yes, result:_____

❒ No

Have you ever had allergy shots (allergy immunotherapy)?

❒ Yes, for how long?_____ Date stopped_____

❒ No

For office use only

Diagnosis: