ALLERGY & ASTHMA SPECIALISTS
W. Donald Cooke, MD, FAAAAI

Patient Information

Last name _____ First name _____ Middle Initial _____

Name you wish to be called _____ Date of birth _____

Mailing address _____ City/State/Zip _____

Email _____ Gender_____

Would you like billing statements e-mailed? □ Yes □ No If so, please add 808MedicalBilling@gmail.com to your address book so e-Statements do not go to your spam folder.

Home # _____ Work # _____ Cell # _____

Social Security # _____ Marital status _____

Employer _____ Occupation _____

Primary care physician _____ Referred by _____

Emergency contact _____ Relationship to patient _____

Contact person's home #_____ Cell #_____

I authorize my insurance to pay for billed services directly to the physician's office. I also authorize release of information to my insurance if requested. I recognize I am responsible for any co-pay, deductibles or non-covered charges as per my insurance policies.

Signature _____ Date _____
Print Name _____

☐**Patient** ☐**Parent or Guarantor (required if patient is under 18)**

Guarantor Information (person responsible for payment): ☐ Self Pay (skip to Policy Holder Information)

****Required if patient under 18 years old****

Last name _____ First name _____

Mailing address: ☐ same as above, or _____

Guarantor Social Security # _____ Relationship to Patient _____

Date of birth _____ Employer _____

Home #_____ Work # _____ Cell # _____

Policy Holder Information (as on insurance card): ☐ Self ☐ Parent ☐ Guarantor (as above) ☐ Partner

Last name _____ First name _____ Date of birth _____

Policy Holder Social Security # _____ Best Phone #_____

Mailing address: ☐ same as patient, or _____

Please add allergydurango@gmail.com to your address book so office correspondence does not go to your spam folder.
Updated 1.25.23

ALLERGY & ASTHMA SPECIALISTS
W. Donald Cooke, MD, FAAAAI

Acknowledgment of Receipt of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have received a copy / or have been offered a copy of Allergy & Asthma Specialists Notice of Privacy Practices with an effective date of 04/03/03.

Privacy Practices:

- We have an optional text messaging system that requires patients to opt in. You can opt out at any time. This system is not secure so please do not share sensitive information such as social security numbers or credit card numbers.
- We can communicate via e-mail; however, our e-mail is not secure so please do not share sensitive information such as social security numbers or credit card numbers.
- It is the policy of this office to confirm patient appointments and leave voice messages at phone numbers provided by our patient/guardian(s).
- It is the policy of this office to leave phone messages requesting our patients to call us concerning health care issues.
- It is the policy of this office to discuss patient's health care information with the patient or guardian. If you wish us to discuss patient's health care information with an alternative individual, please indicate below.

The aforementioned communications may be shared with (other than parent/guardian):

Name (printed)	Phone Number	Relationship to Patient
_____	(____)_____-_____	_____
_____	(____)_____-_____	_____

Signature _____ **Date** _____ ☐ **Patient**

Printed Name _____ ☐ **Parent/Guarantor (if patient under 18)**

For Office Use: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained due to the following:

_____ Individual refused to sign

_____ An emergency situation prevented obtaining acknowledgment at this time.

Staff Signature _____ Date _____

Allergy & Asthma Specialists
W. Donald Cooke, MD, FAAAAI

Financial Policy

Thank you for choosing us for your health care needs. We are dedicated to providing you with the best possible health care and service. We consider the understanding of your financial responsibilities an essential part of your care.

Payment is required for all services AT THE TIME OF SERVICE, unless your services are covered by a contracted insurance. Self-pay patients will receive a discount on applicable services *only if they pay at the time of service* According to the American Medical Association, you are considered a new patient if you have not had an office visit (in-person or telehealth) from our office within the past three years.

If you decide to proceed with Immunotherapy (allergy shots), you verbally agree to have your serum mixed and are responsible for paying any balance regardless of whether you continue your shot regimen.

You are responsible for providing the front and back of all insurance cards at the time of service and updating your insurance as soon as possible if it changes. We will bill up to two insurances as a courtesy. Because insurance plans vary as to allowed amounts, deductibles, coinsurance and copayments, you are responsible for understanding your policy benefits. Also, you acknowledge you are responsible for obtaining preauthorization, if necessary.

Copayments and known balances are due at the time of service, including telehealth visits. If there is a balance remaining, you are responsible to pay the total UPON RECEIPT OF YOUR *1ST STATEMENT* from our billing company. In the event the insurance company overpays, a refund will be issued to you or the insurance company. Credits of $25 or less will be held on your account as a credit balance, unless you request a refund. If your contracted insurance has not paid within sixty (60) days of billing you will be required to contact them to find out why the claim has not been paid. You are then required to pay the account balance unless other arrangements have been made and approved by Allergy & Asthma Specialists and our billing company (505-348-86817153 808MedicalBilling@gmail.com).

If you are unable to pay your balance in full upon receipt of your 1st statement, a reasonable MONTHLY payment plan must be set up with our billing company (505-348-86817153 808MedicalBilling@gmail.com). *If you have asked forstatements to be emailed, please add 808MedicalBilling@gmail.com to your address book so they do not go to your spam folder.*

Failure to pay will result in a delinquent account. Interest and billing fees may be charged on delinquent accounts and will be sent to collections. You will be responsible for all collection costs, including attorney and other collection fees. If sent to collections, you will be required to pay in full before being seen again, or you may be asked to permanently seek care elsewhere in accordance with the guidelines set forth by the Colorado State Board of Medical Examiners.

CANCELLATIONS: Should you need to cancel, or move your appointment, we ask that you do so at least 24 hours in advance. We reserve the right to bill a $100 missed appointment fee.

If applicable, I authorize Allergy & Asthma Specialists and/or its billing agent to release to my insurance or its intermediaries, any information related to the filing of my medical claims, appeals, and authorizations. I authorize the payment of insurance benefits to Allergy & Asthma Specialists.

I have read, understand, and agree to the financial policy of this practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient (18+) OR Parent/Authorized Guardian — Today's Date

Printed Name of Person Above — Date of Birth of Person Above

Allergy & Asthma Specialists
W. Donald Cooke, MD, FAAAAI
1800 East 3rd Ave. Ste 104, Durango, CO 81301
Phone (970) 259-0780 ~ Fax (970) 382-2620

Allergy Questionnaire

How were you referred? Physician (name) _____ Self Referral _____ Other _____
What is your occupation? _____
What problem brings you to this appointment _____

Do you have any of these symptoms? (please check all that apply):

☐ Cough	☐ Sneezing	☐ Itchy eyes	☐ Ear infections	☐ Rash
☐ Phlegm (Color) _____	☐ Runny Nose	☐ Watery Eyes	☐ Blocked Ears	☐ Hives
☐ Wheezing	☐ Post Nasal Drip	☐ Nasal Polyps	☐ Nasal Congestion	☐ Swelling
☐ Chest tightness	☐ Itchy Nose	☐ Poor Sense of Smell	☐ Headaches	☐ Eczema
☐ Shortness of breath	☐ Snoring	☐ Fatigue	☐ Other :	

Please do not write in this area

Check any of the following which may trigger (or cause) symptoms or bother you:

☐ Grass	☐ Cats	☐ Cosmetics	☐ Basements	☐ Exercise	☐ Latex
☐ Hay	☐ Dogs	☐ Aerosol spray	☐ Drafts	☐ Nervousness	☐ Reflux/Heartburn
☐ Wool	☐ Other animals	☐ Perfumes	☐ House dust	☐ Cold air	☐ Head colds
☐ Horse	☐ Beverages	☐ Insecticide	☐ Smoke	☐ Humidity	☐ Sinus infections
☐ Old leaves	☐ Alcohol	☐ Odors	☐ Pollution	☐ Weather changes	
☐ Other :					

When did your symptoms begin? _____ Do your symptoms interfere with daily activities? ☐ Y ☐ N
Number of emergency room visits: _____
Are your symptoms getting worse? ☐ Y ☐ N Do Symptoms interfere with sleep? ☐ Y ☐ N
Are symptoms better away from home? ☐ Y ☐ N Number of days missed from school/work: _____

When are your symptoms worse?

☐ Year round	☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
☐ July	☐ August	☐ September	☐ October	☐ November	☐ December	
☐ At night	☐ In morning	☐ Indoors	☐ Outdoors	☐ At home	☐ At work	☐ At school

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ☐ Y ☐ N
When? _____ How much? _____
Any harmful exposures at work or school? _____
Have chest x-rays or sinus x-rays or cat scans been performed? ☐ Y ☐ N When? _____
Results: _____

Please do not write in this area

Allergy History

Have you been skin tested? ☐ Y ☐ N If Yes, When? _____
Results: _____
Have you had allergy injections? ☐ Y ☐ N If Yes, did they help? ☐ Y ☐ N
Any systemic reaction? ☐ Y ☐ N
Have you had your tonsils or adenoids removed? ☐ Y ☐ N Have you had ear or nose surgery? ☐ Y ☐ N
If Yes, please explain _____

List any food allergies and reactions experienced: _____

List any drug allergies and the reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc.) _____

Describe any reaction to insect stings: _____

Please do not write in this area

Environmental Survey

Approximately how old is your house/apartment? _____
How long have you lived in your house/apartment? _____
Do you live in ☐ the City ☐ Suburbs ☐ Rural
Do you live in a ☐ House ☐ Apartment/Duplex
Do you have a basement? ☐ Y ☐ N
Do you have an air cleaner? ☐ Y ☐ N
Are you built on a slab? ☐ Y ☐ N
Is your house/apartment excessively humid? ☐ Y ☐ N
Do you have water leaks, mold contamination? ☐ Y ☐ N
Do you have problems with roaches? ☐ Y ☐ N
Do you have problems with mice? ☐ Y ☐ N
What type of vacuum cleaner do you have? _____

Type of heating system (check one) ☐ Hot air ☐ Steam (radiator) ☐ Electric ☐ Hot water (baseboard)
Do you have air conditioning? ☐ Y ☐ N If yes, ☐ Window ☐ Central
Do you have: ☐ Wood stove ☐ Coal stove ☐ Humidifier ☐ Dehumidifier
Pets (number) - Indoor or Out door: ☐ Cats_____ ☐ Dogs_____ ☐ Birds____ ☐ Other ____
Are pets in the bedroom? ☐ Y ☐ N
Is your bedroom in the basement? ☐ Y ☐ N
What type of floor covering? ☐ Wall to wall ☐ Animal rug ☐ Area rug ☐ Bare floor
Do you have allergy-proof encasing for pillows or mattresses? ☐ Y ☐ N
What type of comforter do you have in your bedroom? _____
What type of pillow do you have? _____
How old is your mattress? _____ What is in your mattress (i.e. cotton/horsehair)? _____

Do you have stuffed animals in your bedroo ☐ Y ☐ N If so, appr ıte number: _____

Are there any tobacco smokers in your home? ☐ Y ☐ N
Do you smoke now? ☐ Y ☐ N How much? _____
Have you smoked in the past? ☐ Y ☐ N When did you stop? _____

Who in your family has had:
☐ Asthma ☐ Hay fever ☐ Hives ☐ Eczema ☐ Swelling ☐ Other allergies
Please list: _____

Medical History

Check all that apply:

☐ Diabetes ☐ Liver disease ☐ Osteoporosis ☐ Peptic ulcer ☐ Hives ☐ Heartburn
☐ Asthma ☐ Heart problems ☐ Kidney disease ☐ Thyroid ☐ Hay fever ☐ Seizures
☐ High blood pressure ☐ Other:

If yes to any of the above, please explain: _____

Please list any hospitalizations regardless of cause: _____

Please list medications you are presently taking along with the dosages:

Nasal Sprays, Allergy Pills, Eardrops	Asthma Inhalers and Pills	All other meds including over the counter meds

Please do not write in this area

Patient Name: _____ Clinic No. _____
Date: _____ Questionnaire reviewed: _____

REV 10/15/2020 PE

QUESTIONNAIRE FOR PATIENTS WITH RASH

When did the rash start?

Have you had this before, even as a child (circle)? Yes No Unknown

How often are you getting outbreaks (circle)?
Daily
A few times a week
A few times a month
Rarely

How long does this last in one place (circle)?
Less than an hour or two
About a day
More than a day

Have you had any swelling (angioedema) of the following (circle all that apply)?
lips eyes hands feet

Have you been sick anytime in the last few months (circle all that apply)?
cold flu other:

Have you had any other symptoms (circle all that apply)?
nausea diarrhea weight loss fevers joint pain

Is there anything that makes it worse (circle all that apply)? cold exposure heat
hot showers exercise areas of pressure such as belt line or bra strap

What medications have you tried?

Are you on any medications for any other medical problems? Please list, and include all supplements, vitamins, etc. (unless listed elsewhere)

Do you have a history of thyroid trouble (circle)? Yes No

Any change in diet (circle)? Yes No
Please describe:

Comments:

Patient Name (printed) Today's Date