

Welcome to Our Office

Allergy and Dermatology Clinic
2324 Santa Rita Road, Suite #2
Pleasanton, California 94566
Phone (925) 846-5100

Patient Information **Today's Date** _____

Name: _____ Date of Birth: _____ Gender M/F

If Child, Parent's Name: _____ Home Phone: _____

Cell Number : _____ Work Number: _____

E-mail Address: _____

Home Address: _____ City: _____ Zip: _____

Social Security Number: _____ Driver's License Number: _____

Patient's Employer: _____ Phone: _____

Spouse's Employer: _____ Phone: _____

In case of an emergency, please contact: _____ Phone: _____

Your Family/Primary Care Physician: _____ Phone: _____

Insurance Carrier _____ Phone _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Employer _____ I.D.# _____ Grp.# _____

Secondary Insurance _____ Phone: _____

Assignment of Benefits (payment directly to this office by your insurance company).

I, the undersigned, have insurance with _____ and assign directly to the Livermore Allergy Medical Clinic, all medical benefits, if any otherwise payable to me for services rendered in their office. I understand that I am financially responsible for all services rendered, whether or not paid by insurance. I hereby authorize the doctors (clinic) to release all information necessary to secure payment of insurance benefits.

Signed _____ Date _____

Livermore Allergy and Dermatology Clinic

Michael N. Cowan, M.D.

Dean G. Kardassakis, M.D.

Beth L. Cowan, M.D.

Duke Khuu, M.D.

Name: _____ Date: _____

Apt Date: _____ Apt Time: _____

Primary Referring Physician Information

Name _____

Address _____

Phone _____

It is important that we be able to send a copy of your visit information to your primary doctor for long term continuity.

Primary Pharmacy

Credit Card Info.

To hold your appointment
And for Copayment at the time of the visit

Mastercard[]

Visa[]

16 digit Card Number: _____

Exp Date: _____ CVC# _____ (3 digits on the back of card)

We assure you that your information will be handled with the utmost confidentiality.

Allergy Questionnaire

NAME: _____

DATE: _____

Please answer the following questions as completely and as accurately as possible. The information you give will be very important in learning more about your allergy and how to control it.

1. Have you ever had (Answer "Yes" or "No"): Age of onset / Months of Years Affected"

a.) Hay fever (itchy nose, sneezing, stuffy nose, runny nose)? /

YES NO

b.) Asthma (wheezing and shortness of breath)? /

YES NO

c.) Eczema, hives, or other rashes? /

YES NO

d.) Sinus trouble or frequent colds? /

YES NO

Drug allergies (i.e. penicillin, aspirin, sulfa, tetanus, etc.). Which drug: _____
When: _____

2. Have you ever had any of the following (circle)? Colic, croup, pneumonia, frequent headaches, frequent nose bleeds, hearing problems, coughed up blood, heart trouble, high blood pressure, kidney trouble, liver trouble, tuberculosis, tonsils removed, operative on nose. Chest X-rays (date): _____ Sinus X-rays (date): _____

3. Is there a history of allergy in your family? YES _____ NO _____, i.e. parents, grandparents, brothers or sisters, children aunts, or uncles who have (circle): hay fever, eczema, asthma, or hives? Please list: _____

4. What type of work do you do? _____
Are you exposed to anything at work that might aggravate your condition? _____

5. Where do you live (area of city or in country)? _____

Type of house (frame, brick, stone, etc): _____

Type of heating (forced hot air, hot water, steam, space heater, etc): _____

Any filters? _____

Type of rug (wool, nylon, etc) and pad (rubber, ozite hair) in bedroom _____, living room _____, den _____, dining room _____? Number of beds in your

bedroom _____? Is your pillow stuffed with feathers, foam, Dacron, or other _____?

How old is your pillow _____, mattress _____? Do you have any stuffed furniture in the bedroom? _____ Feather comforters? _____

6. Do you have any pets? _____ Dogs, cats, birds, other: _____.
If yes, where do they sleep? _____.
Have you ever noted symptoms after exposure to animals? _____.

7. Have you ever noted symptoms after exposure to: House dust _____, Barn dust or straw _____,
Leaves _____, Cosmetics _____, Flowers _____, Pain _____, Perfumes _____, Insect spray _____.
Have you ever had poison ivy? YES NO

8. Have you ever smoked? What (cigarettes, cigars, pipe)? _____
for how many years? _____ Average per day? _____ If you still smoke do you think that
you could stop? _____

9. Have you noticed any symptoms (rash, hay fever, asthma, stomach ache, loose bowels,
nausea) after any of the following foods (circle): milk, eggs, wheat, berries, melon, fish, shell
fish, peanuts, other nuts, tomatoes, spices, coffee, mustard, chocolate, celery, or ginger.
Explain: _____

10. Have you ever been stung by a bee, wasp, yellow jacket, or hornet? _____
Did you have any unusual reaction (very large swelling, hives, asthma, loss of consciousness)?

11. When did you have your last:
Tetanus booster _____
Small Pox vaccination _____
Polio vaccine _____
Flu shot _____

12. Do you think that tensions or emotions are important factors in your condition? _____

13. Have you ever had allergy skin tests (date) _____? Name of doctor: _____.
Do you recall the results of these tests? _____ If so, please list the positive tests:

14. Have you ever received allergy injections? _____ Dates: _____

15. Please list all medications that you are now taking (if you do not know the name, give the
prescription number and pharmacist's phone number or describe the pill—color, shape):

16. What other medications have you taken in the past?

Please list any other symptoms not covered in questionnaire:

MEDICATIONS LOG

Patient name _____ Date of Birth _____

Allergies to Medications _____ Type of Allergic Reaction _____

Allergies to Medications _____ Type of Allergic Reaction _____

Allergies to Medications _____ Type of Allergic Reaction _____

Allergies to Medications _____ Type of Allergic Reaction _____

Current Medication _____ Dose _____ Date Started _____

Current Medication _____ Dose _____ Date Started _____

Current Medication _____ Dose _____ Date Started _____

Current Medication _____ Dose _____ Date Started _____

Current Medication _____ Dose _____ Date Started _____

Current Medication _____ Dose _____ Date Started _____

Current Medication _____ Dose _____ Date Started _____

Current Medication _____ Dose _____ Date Started _____

Please be aware of the following Policies:

All co-pays are due in full at the time of the visit. There will be a \$10.00 fee assessed for all co-pays not received prior to seeing the physician.

Because there are other patients waiting for appointments, there will be a \$50.00 fee, if you do not cancel 48 hours before your appointment.

Thank you for your cooperation.