ALLERGY ASSOCIATES of UTAH

6095 Fashion Boulevard
Suite 100
Murray, UT 84107
T 801 263.8700
F 801 263.8693

7478 S. Campus View Drive
Suite 200
West Jordan, UT 84084
T 801 282.8700
F 801 282.3305

Thank you for choosing Allergy Associates of Utah for your medical care.

Please complete the included allergy questionnaire and bring it with you to your appointment. Please check in 20 minutes prior to your scheduled appointment time to avoid cancellation. If you do not have time to complete it before your appointment, please arrive at our office at least 40 minutes early to avoid cancellation. If you would like to send in your paperwork or any additional medical records electronically, please contact our office, and the staff will walk you through the process.

Please make sure to bring a current copy of all active insurance card(s) and your identification/driver's license to the appointment. Please also bring a list of any medications you are taking.

AN ALLERGY EVALUATION CAN TAKE UP TO TWO-THREE HOURS. Please do not schedule any other appointments that may conflict with your allergy appointment.

The provider may perform testing to evaluate your medical condition. The type and number of tests may vary depending on the medical problem.

If testing needs to be performed, you should **AVOID** the following allergy medications for the specified times:

- Claritin (Loratadine), Allegra (Fexofenadine), Zyrtec (Cetirizine), Clarinex, Xyzal, Hydroxyzine, Vistaril – **72 hours**
- Benadryl (Diphenhydramine), Lodrane (Bromphenaramine), Chlorpheniramine, DAllergy, Allerx – **48 hours**
- Any other antihistamine or anti-itch pill, cough/cold medication, or allergy pill – **Check with the office**
- Astelin (Azelastine), Astepro, Dymista, or Patanase (Olapatadine) Nasal Spray – **48 hours**
- Patanol (Olapatadine), Pataday, Zaditor (Ketotifen), Optivar (Azelastine), Elestat (Epinastine), or other anti-histamine allergy eye drops – **48 hours**
- Zantac (Ranitidine), Pepcid (Famotidine) – **48 hours**

YOU SHOULD NOT STOP ANY OTHER MEDICATIONS, INCLUDING ASTHMA MEDICATIONS, STEROIDS, OR ANTIBIOTICS, UNLESS DIRECTED BY A HEALTH CARE PROVIDER. If you have any questions, please call our office before your appointment.

Copayments for specialist office visit services are due at time of service and/or a good-faith estimate of your deductible and coinsurance as determined by your medical plan at the time of service. Any questions or payment arrangements can be made with the Business Office prior to your visit at 801-263-8700.

Please notify our office at least 24-48 hours before your appointment if you are unable to keep it. We look forward to meeting you and helping you with your medical care.

Sincerely,

Allergy Associates of Utah
www.utahallergies.com
frontdesk@utahallergies.com

ALLERGY ASSOCIATES OF UTAH

Patient Information

Name: _____ Date of Birth: ____ / ____ / _____ Date: ____ / ____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Occupation: _____

Emergency Contact: _____

Relationship: _____ Phone: _____ Address: _____

Personal Physician: _____ Referred by: _____

Please list other family members who have been seen in this practice: _____

Responsible Party

IF THE PATIENT IS AN **ADULT**	IF THE PATIENT IS A **MINOR**
Employer: _____	Responsible party name: _____
Work Phone: _____	Address: _____
Spouse: _____	City: _____ State: _____ Zip: _____
Employer: _____	Home Phone: _____
Work Phone: _____	Employer: _____

Insurance Information

1st Insurance Company: _____	2nd Insurance Company: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Subscriber ID#: _____	Subscriber ID#: _____
Subscriber Group#: _____	Subscriber Group#: _____

NOTE: IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, PLEASE GIVE YOUR CURRENT, COMPLETED REFERRAL FORMS FROM YOUR PRIMARY CARE PHYSICIAN AS WELL AS YOUR INSURANCE ID CARD TO THE FRONT DESK BEFORE YOU SEE THE DOCTOR. IT IS YOUR RESPONSIBILITY TO COMPLY WITH THE TERMS OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY.

CREDIT POLICIES

1. PAYMENT IS REQUESTED AT THE TIME OF TREATMENT UNLESS SPECIAL ARRANGEMENTS ARE MADE.
2. PAYMENT ON ACCOUNTS BILLED IS EXPECTED WITHIN 30 DAYS.

No finance charge will be made unless the account is not discharged as per agreement. I/We acknowledge this agreement and agree to pay collection costs and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection suit.

Patient/Parental Signature: _____ Date: ____ / ____ / _____

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Allergy Questionnaire

Patient Name: _____ Date of Birth: ____ / ____ / _____ Date: ____ / ____ / _____

Please arrive 20 minutes prior to your appointment time with completed paperwork, ID, insurance card, and medication list to avoid cancellation. Initial visits may take up to 2-3 hours.

Describe the typical symptoms in your own words:

_____

_____

_____

_____

_____

_____

_____

_____

Have you had previous allergy testing? ☐ No ☐ Yes (When and by whom): _____

Please fill out the following sections:

1. Breathing ☐ Does not apply

I have: ☐ Breathing symptoms ☐ Asthma ☐ COPD ☐ Other

Symptoms	How often?					How bad?		
	Never	Rarely	Some days	Most days	Daily	Mild	Moderate	Severe
Shortness of breath	☐	☐	☐	☐	☐	☐	☐	☐
Chest tightness	☐	☐	☐	☐	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐

Breathing Triggers:

☐ Trees	☐ Grass	☐ Weeds	☐ Mold
☐ Cats	☐ Dogs	☐ Dust	☐ Horses
☐ Strong odors/chemicals	☐ Cold air	☐ Exercise	☐ Infection
☐ Winter	☐ Spring	☐ Summer	☐ Fall
☐ Other:		☐ Unknown	☐ NONE

2. Allergies (Nose, Eyes, Sinuses)

☐ Does not apply

Symptoms	How often?					How bad?		
	Never	Rarely	Some days	Most days	Daily	Mild	Moderate	Severe
Nasal congestion	☐	☐	☐	☐	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐	☐	☐	☐	☐
Post-nasal drip	☐	☐	☐	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐
Eye itch	☐	☐	☐	☐	☐	☐	☐	☐
Eye watering	☐	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐	☐
Ear symptoms	☐	☐	☐	☐	☐	☐	☐	☐

Allergy Triggers:

- ☐ Trees
- ☐ Grass
- ☐ Weeds
- ☐ Mold
- ☐ Cats
- ☐ Dogs
- ☐ Dust
- ☐ Horses
- ☐ Strong odors/chemicals
- ☐ Cold air
- ☐ Exercise
- ☐ Infection
- ☐ Winter
- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Other:
- ☐ Unknown
- ☐ NONE

3. Food Reactions

☐ Does not apply

What now or in the past has caused trouble?

_____

_____

What was the reaction?

_____

_____

4. Rashes and Hives

☐ Does not apply

What now or in the past has caused trouble?

_____

_____

What was the reaction?

_____

_____

5. Insect Sting Reactions

☐ Does not apply

Has the patient ever had a severe reaction to a bee, wasp, or hornet sting?

☐ No

☐ Yes (Describe): _____

Allergic Family History and Additional Information

1. Allergic Family History

Please check and list any medical problems that run in your family:

	No Problems	Unknown	Allergies	Asthma	Food Allergies	Eczema	Other (Please list)
Father	☐	☐	☐	☐	☐	☐	
Mother	☐	☐	☐	☐	☐	☐	
Brothers (☐ none)	☐	☐	☐	☐	☐	☐	
Sisters (☐ none)	☐	☐	☐	☐	☐	☐	

2. Additional Infomation

Any allergen exposures at work?

☐ No

☐ Yes: _____

Any pets at home?

☐ No

☐ Yes

- ☐ Cat(s)
- ☐ Dog(s)
- ☐ Other: _____

Do you have a primary care physician?

☐ No

☐ Yes: _____

Did a physician refer you?

☐ No

☐ Yes: _____

How did you hear about us? _____

Preferred local pharmacy: _____

Preferred mail order pharmacy: _____