

Desert Allergy Asthma & Immunology, Ltd.
A. Sean McKnight, M.D.
2821 W. Horizon Ridge Parkway, Suite 101
Henderson, NV 89052
(702) 212-5889

New Patient Medical History and Allergy Survey

Please complete this form. It is important for your doctor to know the details about your medical history and allergy symptoms. If you have questions about completing this form, please ask the medical office staff.

Name: _____ **Age** _____ **Date** _____

Primary Care Physician's Name: _____

Referring Physician's Name: _____

Chief complaint(s) and onset:

Expectations from this allergy/immunology consultation: _____

Do you have any of the following:

Asthma	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Exercise induced asthma	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Allergies/hayfever	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Hives/Urticaria	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Rash	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Eczema	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Food allergy	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Drug allergy	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Insect allergy	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Headache	Yes	___	No	___	Uncertain	___	Date of Onset	_____
Anaphylactic reaction	Yes	___	No	___	Uncertain	___	Date of Onset	_____

Other (please describe): _____

Allergy evaluation:

Have you ever been evaluated by an allergist/immunologist? Yes ___ No ___

Name of previous allergist: _____ Date last seen: _____

City/State of previous allergist: _____

Have you had any "blood work" to determine if you have allergies? Yes ___ No ___

Have you ever been "skin tested" to evaluate allergies? Yes ___ No ___ Uncertain ___

If "yes", what were you allergic to (check all that apply):

Trees ___ Grasses ___ Weeds ___ Cat ___ Dog ___ Dust mites ___ Molds ___
Cockroaches ___ Food ___

Have you ever been on "allergy injections/immunotherapy"? Yes ___ No ___ Uncertain ___

If "yes": When did you start: _____

How long did you receive immunotherapy? _____

Did you find it beneficial? Yes ___ No ___ Uncertain ___

Did you have any significant reactions after injections: No ___ Yes ___ Describe: _____

Nasal and Eye Allergy Symptoms:

Onset of Allergy symptoms (age): _____

How long have you lived in Las Vegas/Henderson? _____

Where have you previously lived? _____

Do you have daily symptoms: Yes ___ No ___ Seasonal ___

Are your allergy symptoms getting worse: Yes ___ No ___ Constant ___

What time of year are your allergy symptoms worst (check all that apply):

Spring ___ Summer ___ Fall ___ Winter ___

Do any particular exposures make your allergies worse (check all that apply):

Cats ___ Dogs ___ Smoke ___ Grass ___ Perfume ___ Strong odors ___

Other allergy triggers: _____

How is your sense of smell: Excellent___ Good ___ Poor ___ None ___

Do you have discolored nasal discharge? Yes___ No___

If yes, what color and how long have you had it? Color:_____ Onset:_____

Check all allergy symptoms that you have:

Eyes: Itching___ Swelling___ Burning ___ Runny ___ Watery___ Discharge___ Pain___

Ears: Itching___ Fullness___ Popping___ Decreased hearing___ Pain___

Nose: Itching___ Sneezing___ Runny nose___ Congestion___ Stuffy nose___ Obstruction___

Mouth breathing___ Nasal pressure or pain___ Nasal polyps___

Throat: Itching___ Soreness___ Post nasal drip___ Throat clearing___ Swelling___

How many times in a row do you sneeze?_____

Do you currently use a nasal spray? Yes___ No___ Name:_____

Do you currently use an antihistamine? Yes___ No___ Name:_____

Do you ever use nasal saline spray? Yes___ No___ Never___

Do you use nasal saline irrigation? Yes___ No___ Never___

Do you use "Afrin" or other over the counter nasal decongestant spray? Yes___ No___ If "yes", for how long:_____

Have you ever had a CT (CAT scan) of your sinuses? Yes___ No___

If "yes", Date/results:_____

Have you ever had sinus surgery? Yes___ No___ If "yes", when:_____

Have you been evaluated by an ENT/Otolaryngologist? Yes___ No___ If "yes", who and when:_____

Respiratory:

Do you cough? Yes___ No___ Onset of cough:_____

Do you wheeze? Yes___ No___ Onset of wheezing:_____

Have you ever been diagnosed with any of the following:

Asthma: Yes___ No___ Age of diagnosis:_____

COPD: Yes___ No___ Age of diagnosis:_____

Emphysema: Yes___ No___ Age of diagnosis:_____

Pneumonia: Yes___ No___ How many times:_____ Age of diagnosis:_____

Bronchitis: Yes___ No___ Age of diagnosis:_____

Do you cough at night? Yes___ No___ How many times per month:_____

Do you wheeze at night? Yes___ No___ How many times per month:_____

Do you cough with activity? Yes___ No___ How many times per month:_____

Do you wheeze with activity? Yes___ No___ How many times per month:_____

What activities cause you to cough or wheeze (check all that apply):

Walking___ Walking up stairs___ Running___ Exercise___

Do you cough when you laugh? Yes___ No___

Have you had a chest X-ray? Yes___ No___ Date/results:_____

Have you had a chest CAT Scan? Yes___ No___ Date/results:_____

Have you had lung function testing? Yes___ No___ Date/results:_____

Do you currently use "Albuterol"? Yes___ No___ Nebulizer___ Meter dose inhaler___

How many times per week do you use Albuterol?_____

Do you use any other respiratory medications? Yes___ No___

Have you used any of the following medications (check all that apply):

Advair___ Flovent___ Pulmicort___ Asmanex___ Qvar___ Foradil___ Serevent___

Combivent___ Singulair___ Albuterol___

If "yes", did any of the medications help your breathing: Yes___ No___ Uncertain___

Which medications helped you the most (check all that apply):

Advair___ Flovent___ Pulmicort___ Asmanex___ Qvar___ Foradil___ Serevent___

Combivent___ Singulair___ Albuterol___

What triggers your respiratory symptoms (check all that apply):

Upper respiratory infection___ Change in weather___ Exercise___ Cold weather___

Hot weather___ Wind___ Smoke___ Strong odors___ Perfume___ Work related___

Have you ever been intubated or on a ventilator? Yes___ No___

Have you ever been admitted to the ICU or PICU? Yes___ No___

How many times in your life have you been on oral steroids:_____

When was your last course of oral steroids:_____

Have you ever had a "Bone density" study? Yes___ No___

Do you have osteopenia? Yes___ No___ Do you have osteoporosis? Yes___ No___

Do you use a peak flow meter? Yes___ No___ If "yes", what is your best peak flow (liters/min):_____

Eczema:

Have you ever been diagnosed with eczema? Yes ___ No ___ (If "No", go to next section)

Age at onset of eczema? _____

Triggers of eczema (check all that apply):

Food allergy ___ Milk ___ Egg ___ Nut ___ Cat ___ Dog ___ Dry weather ___ Cold weather ___

Grass exposure ___ Swimming pool ___ Bathing ___ Other: _____

Do you use daily moisturizer? Yes ___ No ___

Do you use a topical steroid? Yes ___ No ___

Have you ever had a severe skin infection requiring antibiotics? Yes ___ No ___ How many times? _____

Do you have a dermatologist? Yes ___ No ___ Name of physician: _____

Have you been evaluated for food allergy? Yes ___ No ___

Rash: (If NO rash, don't complete this section)

When did your rash first start? _____

On what part of your body did your rash first appear? _____

Has your rash got: Better ___ Worse ___ No change ___

Does your rash "come and go"? Yes ___ No ___ Constant ___

Describe the circumstances surrounding the onset of your rash: _____

What do you think caused your rash? _____

Does the rash itch: Yes ___ No ___ Uncertain ___

What size are the individual rash lesions? _____

What time of day is your rash worse? AM ___ PM ___ No difference ___

Is there any pattern or cycle that your rash follows? No ___ Yes ___ Describe: _____

Have you identified any place where your rash is worse? (check all that apply):

Indoors ___ Outdoors ___ Home ___ Work ___ School ___ Vacation ___ No difference ___ Other: _____

What medications have you used to control your rash:

1. _____ Effective ___ Not effective ___

2. _____ Effective ___ Not effective ___

3. _____ Effective ___ Not effective ___

4. Steroids: _____ Effective ___ Not effective ___

Do any of the following factors trigger your rash or make it worse? (check all that apply)

Aspirin ___ Alcohol ___ Food ___ Cold ___ Heat ___ Hot bath ___ Water ___ Exercise ___ Emotions ___

Sunlight ___ Exertion ___ Sweating ___ Vibration ___ Medication ___ Metal exposure ___ Tight clothes ___

Have you had any of the following symptoms associated with your rash? (check all that apply)

Excessive sweating ___ Diarrhea ___ Headaches ___ Abdominal cramps ___ Fever ___ Muscle pains ___

Joint swelling ___ Joint pain ___ Joint stiffness ___ Fatigue ___

Have you traveled outside of the United States immediately prior to onset of the rash? No ___ Yes ___ Where: _____

Did you start any new medications prior to the onset of the rash? No ___ Yes ___ Medication: _____

Drug Allergy:

If "no known drug allergies", place check next to none and proceed to next section: None ___

Please list all drug allergies, date, and reaction(s)

1. Drug: _____ Date/Age: _____ Reaction: _____

2. Drug: _____ Date/Age: _____ Reaction: _____

3. Drug: _____ Date/Age: _____ Reaction: _____

4. Drug: _____ Date/Age: _____ Reaction: _____

5. Drug: _____ Date/Age: _____ Reaction: _____

6. Drug: _____ Date/Age: _____ Reaction: _____

7. Drug: _____ Date/Age: _____ Reaction: _____

Food Allergy:

If "no known food allergies", place check next to none and proceed to next section: None ___

Please list all food allergies, date, and reaction(s)

1. Food: _____ Date/Age: _____ Reaction: _____

2. Food: _____ Date/Age: _____ Reaction: _____

3. Food: _____ Date/Age: _____ Reaction: _____

4. Food: _____ Date/Age: _____ Reaction: _____

5. Food: _____ Date/Age: _____ Reaction: _____

6. Food: _____ Date/Age: _____ Reaction: _____

7. Food: _____ Date/Age: _____ Reaction: _____

Do you have an EpiPen or EpiPen Jr? Yes___ No___
Have you ever used your EpiPen or received epinephrine? Yes___ No___ Uncertain___
Have you ever been seen in the Emergency Room for food allergy: Yes___ No___
Are you familiar with the Food Allergy and Anaphylaxis Network? Yes___ No___

Insect Allergy:

Have you ever had a "life threatening reaction" to a stinging insect? Yes___ No___
If "No", proceed to the next section, otherwise:
If "yes": Date_____ Suspected insect_____ Reaction_____
Date_____ Suspected insect_____ Reaction_____
Date_____ Suspected insect_____ Reaction_____

Do you have an EpiPen or EpiPen Jr? Yes___ No___
Have you ever used your EpiPen or received epinephrine? Yes___ No___ Uncertain___
Have you ever been seen in the Emergency Room for insect allergy: Yes___ No___
Have you ever been on "immunotherapy" for insect allergy? Yes___ No___ Uncertain___

Environmental History:

Do you live in a: House___ Condo___ Apartment___ Mobile Home___ RV___ Assisted living___ Other_____
Do you have any pets? Yes___ No___
If "yes", how many of the following: Cats___ Dogs___ Hamsters___ Ferrets___ Birds___ Snakes___
Are the pets allowed inside the bedroom? Yes___ No___
Do you have carpeting in the bedroom? Yes___ No___
Do you use a humidifier? Yes___ No___ Do you use central air conditioning? Yes___ No___
Do you use a HEPA filter? Yes___ No___ Do you use an "Ionic Breeze" or similar? Yes___ No___
How many people live with the patient (number): _____
Who lives with the patient (i.e. mom, dad, wife, etc.): _____
Does anyone who lives with the patient smoke? Yes___ No___
Does anyone smoke in the house? Yes___ No___ Does anyone smoke in the car? Yes___ No___

Birth History: (Only to be completed if the patient is < 10 years old)

Place of birth (city/state): _____
Full term: Yes___ No___ If "No", how many gestational weeks: _____
Check type of birth: Vaginal birth___ OR C-Section___
Birth Weight: _____
Did the baby stay in the NICU? No___ Yes___ If "yes", for how long?: _____ Ventilator? Yes___ No___
Complications: No___ Yes___ If "Yes", please describe: _____
Breast fed: Yes___ No___ If "yes", for how long: _____
Formula type: Cow's milk based___ Soy___ Lactose Free___ Nutramigen___ Alimentum___ Other_____
Age started solid foods: _____

MEDICATIONS

Please list all current medications and reason for taking:

1. _____ Reason for taking: _____
2. _____ Reason for taking: _____
3. _____ Reason for taking: _____
4. _____ Reason for taking: _____
5. _____ Reason for taking: _____
6. _____ Reason for taking: _____
7. _____ Reason for taking: _____
8. _____ Reason for taking: _____
9. _____ Reason for taking: _____
10. _____ Reason for taking: _____

Please list all over the counter and herbal/vitamins that you are taking:

1. _____ Reason for taking: _____
2. _____ Reason for taking: _____
3. _____ Reason for taking: _____
4. _____ Reason for taking: _____
5. _____ Reason for taking: _____
6. _____ Reason for taking: _____
7. _____ Reason for taking: _____
8. _____ Reason for taking: _____

PAST MEDICAL HISTORY

Operations/Surgery (Name and date of procedure)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Hospitalizations (Where, reason, date, and length of stay)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Medical Problems (Problem and date diagnosed)

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

Immunizations:

Are your immunizations up to date? Yes___ No___
 Have you had a recent influenza vaccine? Yes___ No___ Date of last dose: _____
 Have you had a Pneumovax / Prevnar (Pneumonia) vaccine? Yes___ No___ Date of last dose: _____
 Date of last tetanus vaccine: _____

Social History: (Adults and adolescents)

Do you smoke (check all that apply)? Yes___ No___ Never___ Quit___
 If "yes", how much do you smoke? _____ packs per day Age started: _____
 If you "Quit", when did you quit? _____ How many years did you smoke? _____
 How many packs did you smoke per day (average)? _____
 Are you exposed to "passive smoke" from another household member? Yes___ No___
 Do you drink alcohol? Yes___ No___
 Average drinks per day: _____ Type of alcohol: Beer___ Wine___ Liquor___
 Do you use "recreational drugs"? Yes___ No___ If "yes", what type: _____
 Do you consider yourself at "high risk" for HIV? No___ Yes___ If "yes", why: _____
 Have you ever had a blood transfusion? No___ Yes___ If "yes", why: _____
 Caffeine use (drinks/day): _____
 Exercise (times/week): _____ Type of exercise: _____
 Seatbelt use (%): 100___ 75___ 50___ 25___ Never___
 Sun exposure: Frequently___ Occasionally___ Rarely___
 Sunscreen use: Frequently___ Occasionally___ Rarely___
 Occupation: _____
 Exposure to toxic or noxious chemical/substances: No___ Yes___ Describe: _____

Social History: (If < 13 years old)

Is the patient exposed to "passive smoke" from another household member? Yes___ No___
 Seatbelt use (%): 100___ 75___ 50___ 25___ Never___
 Sun exposure: Frequently___ Occasionally___ Rarely___
 Sunscreen use: Frequently___ Occasionally___ Rarely___
 Blood transfusion? No___ Yes___ If "yes", why: _____
 Daycare: Yes___ No___ If "yes", age started attending: _____
 School: Yes___ No___ Grade: _____ Performance: Excellent___ Good___ Fair___ Poor___

Immunology Evaluation: (Only complete if recurrent infections)

Have you ever been diagnosed with a primary immunodeficiency? No___ Yes___

If "yes", please describe: _____

Have any family members ever been diagnosed with an immunodeficiency? No___ Yes___

If "yes", please describe: _____

Have you ever been diagnosed with any of the following: (check all that apply)

Pneumonia___ Meningitis___ Osteomyelitis___ Sepsis___ Severe Skin Infection___ Bronchiectasis___

Cystic Fibrosis___ IgA deficiency___ HIV___ AIDS___ Antibody deficiency___ Complement deficiency___

Common Variable Immunodeficiency___ Other: _____

How many times have you had pneumonia? _____ How many per year? _____

How many sinus infections have you had in your life? _____ How many per year? _____

How many ear infections have you had in your life? _____ How many per year? _____

How many throat infections have you had in your life? _____ How many per year? _____

Have you ever received intravenous immunoglobulin (IVIG) therapy? No___ Yes___

If "yes", please describe: _____

Have you ever been evaluated for primary immunodeficiency? Yes___ No___

Have you ever been tested for HIV? Yes___ No___ If "yes", last date and result: _____

Family History

Are there any members of the immediate family who have asthma, hay fever, eczema, rash, food allergies, drug allergies, insect allergies, arthritis, recurring and/or frequent infections? Please list and comment.

Are there any hereditary diseases or other disorders that seem to occur frequently in your family (diabetes, emphysema, heart problems)?

Comments:

Review of Systems

Do you currently have any of the following? (Check)

Allergy

- Asthma
- Hay fever
- Drug allergy
- Food allergy
- Insect allergy
- Recurrent infections
- Recurrent ear infections
- Recurrent sinus infections
- Recurrent pneumonia

General

- Fever
- Chills
- Night sweats
- Poor appetite
- Fatigue/Weakness
- Weight loss
- Weight gain
- Sleep disorder
- Headaches
- Facial pain
- Depression
- Anxiety

Eyes

- Eye itching
- Eye swelling
- Eye burning
- Eye tearing
- Eye discharge
- Eye irritation
- Vision loss
- Eye pain
- Photophobia

Ears

- Itchy ears
- Ear pain
- Ear discharge
- Ringing
- Decreased hearing
- Popping of ears
- Fullness of ears

Nose/Throat

- Nasal congestion
- Sneezing
- Itchy nose
- Runny nose
- Discolored nasal discharge
- Nosebleeds
- Post nasal drip
- Nasal obstruction
- Sore throat
- Hoarseness
- Itchy throat
- Frequent throat clearing
- Throat swelling

Cardiovascular

- Chest pains
- Palpitations
- Chest pain with exercise
- Ankle swelling

Respiratory

- Cough
- Coughing at night
- Wheezing
- Wheezing at night
- Wheezing with activity
- Exercise induced cough
- Reduced exercise tolerance
- Discolored sputum
- Coughing up blood
- Snoring

GI

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Gas/bloating
- Indigestion/heartburn
- Difficulty swallowing
- Frequent burping
- Frequent belching
- Sour taste in mouth/throat

Derm

- Hives
- Eczema
- Swelling
- Rash
- Itching
- Dry skin
- Suspicious lesions

To the best of my knowledge, I have answered the complete questionnaire.

Reviewed form with the patient in its entirety.

Signature

Sean McKnight, M.D.

Registration Form

Desert Allergy Asthma & Immunology, Ltd.
2821 W. Horizon Ridge Parkway, Suite 101
Henderson, NV 89052
(702) 212-5889

Date: _____

Patient Information

Name (First, Middle, Last) _____ Soc. Sec. #: _____

Address: _____ Email: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Sex: Male Female Age: _____ Date of Birth (M/D/Y) ____/____/____

Marital Status: Single Married Separated Divorced Widowed Minor

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Empl/School Phone: (____) _____

Primary Physician: _____ Office Phone (____) _____

Were you referred by a physician: Yes No If yes, by whom: _____

How did you learn of our practice? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person responsible for account (First, Middle, Last name): _____

Relation to patient: _____ Date of Birth (M/D/Y) ____/____/____ Soc. Sec. #: _____

Address (if different from patient's): _____ Phone: (____) _____

City: _____ State: _____ Zip code: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Bus. Phone: (____) _____

Insurance Company: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered under this plan: _____

Additional Insurance

Is the patient covered by additional insurance? Yes No

Subscriber Name First, Middle, Last name): _____

Relation to patient: _____ Date of Birth (M/D/Y) ____/____/____ Soc. Sec. #: _____

Address (if different from patient's): _____ Phone: (____) _____

City: _____ State: _____ Zip code: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Bus. Phone: (____) _____

Insurance Company: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered under this plan: _____

Registration Form

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Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. Andrew Sean McKnight all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agent for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Desert Allergy Asthma & Immunology, Ltd.
A. Sean McKnight, M.D.
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(702) 212-5889

Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs, we will work with you. The following information is provided to help avoid any misunderstandings about the bill for professional services rendered.

Our office participates in a variety of insurance plans. It is **your responsibility** to:

- **Bring your insurance card for each visit.**
- **Be prepared to pay your co-pay, deductible, or co-insurance at the time services are rendered. Payment can be made by cash, Visa, or MasterCard.**
- **Payment in full is expected at the time services are rendered.**

If you have insurance with which we are not contracted, we will file the claim if you have out-of-network benefits. Any deductible or co-insurance that you are responsible for is due at the time of service. If your insurance does not provide out-of-network benefits, then you are responsible for payment in full.

If you are unable to pay for necessary medical care, you may be eligible for financial assistance based on hardship guidelines. Please inform us prior to your visit. Financial hardship cases are for patients without medical insurance.

Referrals: It is your responsibility to provide required referrals prior to the visit. If you do not have a referral, your visit will be rescheduled or you may be financially responsible for payment in full.

If the patient is younger than 18 years old, the patient's legal guardian must sign below. When a minor is seen, all of the same rules and regulations apply.

Our practice firmly believes that a good physician/patient relationship is based on understanding and good communications. Questions about financial arrangements should be directed to the billing office.

If you are unable to keep your scheduled appointment, please have the courtesy of calling and canceling your appointment. By doing so, we will have the opportunity to fit another person into our schedule. You

understand that you are financially liable for a **\$50.00** non-cancellation fee if your appointment is not cancelled 24 hours prior to the scheduled time.

.....
I have read and understand this financial policy. I understand that for non-covered treatment, I will be responsible for payment in full at the time of service. I understand that there is a non-cancellation fee that I am responsible for paying if appointments are not properly cancelled.

Patient or Responsible Party's **PRINTED** Name

Patient or Responsible Party's **SIGNATURE**

Date

Co-Responsible Party's **PRINTED** Name

Co-Responsible Party's **SIGNATURE**

Date

Desert Allergy Asthma & Immunology, Ltd.
2821 W. Horizon Ridge Parkway, Suite 101
Henderson, NV 89052
(702) 212-5589

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Desert Allergy Asthma & Immunology, Ltd. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Desert Allergy Asthma & Immunology, Ltd.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Desert Allergy Asthma & Immunology, Ltd. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Desert Allergy Asthma & Immunology, Ltd. Privacy Officer at 2821 W. Horizon Ridge Parkway, Suite 101, Henderson, NV 89052.

With my consent, Desert Allergy Asthma & Immunology, Ltd. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Desert Allergy Asthma & Immunology, Ltd. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Desert Allergy Asthma & Immunology, Ltd. may e-mail to me appointment reminder cards and patient statements. I have the right to request that Desert Allergy Asthma & Immunology, Ltd. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Desert Allergy Asthma & Immunology, Ltd.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Desert Allergy Asthma & Immunology, Ltd. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

Desert Allergy, Asthma & Immunology, Ltd
Sean McKnight, M.D.
2821 W. Horizon Ridge Parkway, Suite 101
Henderson, NV 89052

Patient Consent for Photography

Patient Name: _____ DOB: _____ Date: _____

I _____ hereby authorize Sean McKnight, M.D. and Desert Allergy, Asthma & Immunology, Ltd. to take photographs of me or my child in whole or part. I understand that these photographs may be used for medical purposes, such as documenting or planning my care. This photo will be used in the chart in our electronic medical records area. The photo helps to identify patients and prevent medical errors.

Signature of Patient or Guardian

Date

Signature of Witness

Date