PATIENT INFORMATION

Tufts Med. Ctr. MR # _____

PATIENT NAME: _____D.O.B. _____

Address: _____

City: _____State:_____Zip:_____

Home Phone#: _____Cell Phone#_____

Email address: _____

Gender: _____ // Marital Status: _____ // Social Security #_____- _____- _____

Name of Co. /Employer or School:_____Work:#_____

Name of Primary Care Physician: _____

M.D.'s Phone #: _____ Fax#_____

M.D.'s Address: _____

M.D.'s City/Town_____ State_____

INSURANCE INFORMATION

Name of your **Primary Insurance Co**: _____

Address: _____

Policy Holder Name: _____ D.O.B.: _____

Employer: _____

Policy #: _____Group # (if applicable) _____

What is **co-pay** amount for office visit to **specialist**? _____

Are referrals needed**? Y or N** Did you obtain a referral for today's visit? _____

Any **Secondary** Insurance? _____ Phone#: _____

Address: _____

Policy Holder Name: _____ D.O.B.: _____

Employer: _____

Policy #: _____Group #: _____

What is copay amount for office visit to specialist? _____ Are referrals needed? **Y or N**

PHARMACY INFORMATION

**** What Pharmacy do you use?** _____

Address: _____

Town/City: _____State: _____

Telephone #:_____

Release of Information: I authorize the release of any medical information or other information necessary to process my claims. I also request payment of government benefits either to me or the party who accepts assignment.

Authorize of payment: I authorize payment of medical benefits to the physician or supplier for services rendered.

Financial Responsibility: I understand that certain charges may not be covered by my medical insurance and I am financially responsible for all charges incurred, including co-payments and deductibles.

_____

SIGNATURE of Patient/Guardian/Parent Date

Tufts Medical Center, Allergy Division, 800 Washington St., Boston, MA 02111, (617) 636-5333, FAX: (617) 636-4843

Name: Date of Birth: Date of Appointment:

HISTORY OF PRESENT ILLNESS: Briefly describe the reason for your visit to Tufts Medical Center Allergy and what you hope to accomplish.

What diagnoses have you been given by your doctor(s) or that you strongly suspect? (Please check ALL that apply)

✓	Diagnosis	Date of diagnosis (month/year)	✓	Diagnosis	Date of diagnosis (month/year)
	Asthma			Insect sting allergy	
	COPD or emphysema			Lactose intolerance	
	Chronic Bronchitis			Gluten/wheat sensitivity	
	Recurrent sinusitis			Sleep apnea	
	Nasal allergy				
	Hives (urticarial)				
	Food allergy				
	Eczema				

What allergy related symptoms do you currently have? (Please check ALL that apply)

	Wheezing		Sleep interference		Frequent headaches		Other (list)
	Shortness of breath		Nasal congestion		Heartburn/Reflux		
	Chest tightness		Runny nose		Skin itching		
	Limitation of exercise		Sneezing		Dry skin		
	Hoarseness		Eye itching/redness/watering		Skin rash		
	Chronic cough		Post nasal drainage		Other		

What other kind of symptoms or conditions do you have? (Please circle those that apply)

General	Fever / Chills / Weight gain / Weight loss / Frequent infections
Hearing	Hearing loss / Ringing in Ears / Hearing Aid
Vision	Glasses / Contact Lenses / Cataracts / Glaucoma / Double Vision / Retina problems
Heart and circulation	Chest pain / Palpitations / Bleeding / Leg Ulcers / Phlebitis / Peripheral Vascular Disease
Digestive	Heartburn / Reflux / Nausea / Vomiting / Gastritis / Diarrhea / Constipation / Colitis
Liver	Hepatitis C / Hepatitis B / Other Hepatitis / Cirrhosis / Gallstones
Urinary System	Trouble Urinating / Burning / Frequent urinating / Urinary infections / Incontinence / Stones
Musculoskeletal	Gout / Fibromyalgia / Osteoporosis / Osteoarthritis / Rheumatoid arthritis / Other arthritis
Neurologic	Headache / dizziness / fainting / loss of consciousness / memory loss
Endocrine	Intolerance to hot or cold / flushing / increased thirst
Mental Health	Depression / Mood swings / Anxiety / Panic attacks / Schizophrenia

Are your symptoms worse consistently at certain times of year?

Seasonal Incidence (indicate relative intensity, +, ++, +++, ++++)

Symptom (in order of severity)	Year long back-ground symptoms	Early Spring Mar/Apr	Late Spring May/June	Mid Summer July/early Aug	Early Fall Aug/Sept	Late Fall Oct/Nov	Winter Dec-Feb

Factors that aggravate your symptoms:

	Exercise		Dogs		Stress		Other (list)
	Cold air		Other animals		Foods (list)		
	Heat humidity		Odors/perfumes				
	Cats		Smoke				

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Your current environment:

	Live in House/Condo		Radiator/baseboard heat		Water damage		Occupation:
	Live in apartment		Hot air heat		Visible mold growth		Work environment
	For how long?_____		Central A/C		Indoor animal exposure		carpeted
	How old is structure? ___		Window/wall A/C unit		Cat – in bedroom Y / N		Central A/C
	Wall to wall carpeting		Feather pillow		Dog – in bedroom Y / N		Water damage/mold
	Cockroaches		Feather comforter		Other		Irritants/chemicals
	Mice		Indoor cigarette smoke				Smoke

Smoking history

	Never smoked cigarettes	
	Current smoking: cigs/day:	
	Previous smoking	Ave pack/day start and stop year
	Pipes	
	Cigars	

Family history of allergy (immediate family)

Mother
Father
Siblings
Children

Medications (attach an additional sheet if necessary): Please list your current oral and inhaled medications, including medication name, dose, and the number of times per day you take it and whether you take it regularly or only "as needed."

Oral Medications	Tablet Strength	# of Times Per Day	Regular Use	Only "As Needed"	Comments
Inhaled Medications or nasal sprays	**Puffs/or Strength**	**# of Times Per Day**	**Regular Use**	**Only "As Needed"**	**Comments**

Medications that have been effective in the past?

Medications that have NOT been effective in the past?

Drug Allergies/Adverse Reactions If None, please CHECK HERE. ☐

Name of Medication	Nature of Allergic/Adverse Reaction	Comments including when it occurred

Operations and Hospitalizations? (list approximate date and type of operation or diagnosis)

Previous allergy evaluations (please indicate approximately when you were evaluated in the past and what the results were to the best of your memory)

Previous allergy shot therapy (indicate approximate duration of treatment and its effectiveness and when received)

_____ Patient signature and date

_____ Physician's signature and date

HEALTH INFORMATION EXCHANGE CONSENT FORM
Allergy & Asthma Center of Boston, Boston Allergy & Asthma Consultants, PC, and John Leung, MD (Medical Care Provider)
A Member of New England Quality Care Alliance, Inc.

As you may know, your Medical Care Provider is a member of a network of healthcare providers called New England Quality Care Alliance, Inc., (NEQCA) which is a not-for-profit organization. In this Consent Form, you are being asked to choose whether or not you will allow a subset of your medical information from this Medical Care Provider, your other NEQCA and Tufts Medical Center (Tufts MC) providers to be viewed in a secure computer network operated by Tufts MC and NEQCA called the Tufts MC/NEQCA Health Information Exchange (HIE). This subset of information, which is further defined in the box below, could be accessed by providers within Tufts MC and NEQCA. Tufts MC and NEQCA may also send this subset of information through any secure means, including mail, fax, secure state-wide health information exchange known as the Massachusetts Health Information Highway ("Mass HIway"), or other secure electronic transmission to other external providers or organizations involved in your care in order to allow your care to be coordinated more comprehensively and seamlessly. Your Medical Care Provider, your other NEQCA and Tufts Medical Center (Tufts MC) providers may also request additional information from these other providers and organizations through any secure health information exchange for your care coordination. This subset of information may also be used to check whether you have health insurance and what it covers and to evaluate and improve the quality of medical care provided to you and other patients. The only individuals that will have access to this subset of your clinical information are your medical care provider, providers in the Tufts MC/NEQCA network, other external providers or organizations involved in your care, authorized personnel of these providers or organizations, NEQCA's quality and efficiency medical director and personnel, and others whose job it is to maintain, secure, monitor, and evaluate the operation of the Tufts MC/NEQCA HIE. The subset of information will not include your entire medical record. It will only include summary information in the following categories if the information exists in your medical record:

Patient demographics	Insurance information	Advance directives	Problems/diagnoses
Allergies and alerts	Medication list (includes medications prescribed by providers outside the Tufts MC/NEQCA network)	Immunizations	Family history
Social history	Vital signs	Medical test results	Procedures
Encounters	Medical equipment	Plan of care	Health care providers

The information contained in the HIE is based on standards developed by the Massachusetts Medical Society, the Healthcare Information and Management Systems Society, the American Academy of Family Providers, and the American Academy of Pediatrics (among other organizations). It will include sensitive information from your medical record including, but not limited to, information related to mental health conditions and treatment for these conditions, venereal diseases/sexually transmitted diseases, abortion(s), domestic abuse, rape/sexual assault, substance (drug and alcohol) abuse and treatment for substance abuse, genetic diseases and genetic testing and test results, mammograms, and HIV/AIDS. **As part of this Consent Form, you specifically consent to the release of this and other sensitive health information and you acknowledge that you are waiving your legal rights under Massachusetts law to specifically authorize disclosure of this information.**

You may use this Consent Form to decide whether or not to allow Tufts MC or NEQCA providers to view your medical information in the HIE. You can give consent or deny consent, and you can change your mind at anytime by completing a new Consent Form and selecting a different option. **Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to providers in the Tufts MC/NEQCA network and other providers or organizations involved in your care and, as a result, these providers and organizations may have limits on their ability to coordinate your care.**

If you check the **"I GIVE CONSENT"** box below, your Medical Care Provider, your other NEQCA and Tufts Medical Center (Tufts MC) providers may view my information in the secure computer network operated by NEQCA and Tufts MC, and this information may be accessed by, sent securely to, and requested from authorized individuals, including providers within the Tufts MC/NEQCA network and other providers and organizations involved in my care, for the purposes described in this form."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Tufts MC and other NEQCA providers may not view my medical information from this Medical Care Provider in the secure computer network operated by NEQCA and Tufts MC. If you deny consent, only basic demographic information and your decision to deny consent will be seen in the HIE.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

☐ **I GIVE CONSENT for** my Medical Care Provider, my other NEQCA and Tufts Medical Center (Tufts MC) providers to view my information in the secure computer network operated by NEQCA and Tufts MC. Tufts MC and NEQCA may also send my information through any secure means, including mail, fax, secure state-wide health information exchange known as the Massachusetts Health Information Highway ("Mass HIway"), or other secure electronic transmission to other providers or organizations involved in my care, for the purposes described in this form, including for emergency care. I also consent to allow this Medical Care Provider to request additional information from these other providers and organizations through any secure health information exchange. **Providing consent today will override any previous denial of consent.**

☐ **I DENY CONSENT for** Tufts MC and my other NEQCA providers to view my information from this Medical Care Provider in the secure computer network operated by NEQCA and Tufts MC for any purpose, **even in a medical emergency**. I also deny consent for this Medical Care Provider to request additional information from other providers and organizations involved in my care through any secure health information exchange (i.e. Mass HIway).

_____ _____
Print Name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date and Time

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable)

Details about patient information in the Tufts MC/NEQCA HIE and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by providers in the Tufts MC/NEQCA network, other providers or organizations involved in your care, authorized personnel of these providers and organizations, NEQCA's quality and efficiency medical director and personnel, and others whose job it is to maintain, secure, monitor and evaluate the operation of the Tufts MC/NEQCA HIE **only** to:
   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients
   - Perform administrative management of the Tufts MC/NEQCA HIE

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. .

2. What Types of Information about You Are Included. If you give consent, your Tufts MC providers, and your other NEQCA providers may view a subset of information that was placed into the Tufts MC/NEQCA HIE by your Tufts MC and NEQCA providers. Both Tufts MC and NEQCA are not-for-profit organizations. This subset of information could also be accessed by other providers and organizations involved in your care in order to allow your care to be coordinated more comprehensively and seamlessly. This includes information created *before and after* the date of this Consent Form. This subset of information will not include your entire medical record. It will only include summary information in the following categories if the information exists in your medical record:

Patient demographics	Insurance information	Advance directives	Problems/diagnoses
Allergies and alerts	Medication list (includes medications prescribed by providers outside the Tufts MC/NEQCA network)	Immunizations	Family history
Social history	Vital signs	Medical test results	Procedures
Encounters	Medical equipment	Plan of care	Health care providers

As part of this Consent Form, you specifically consent to the release of sensitive health information from your medical record, including, but not limited to, information related to mental health conditions and treatment for these conditions, venereal diseases/sexually transmitted diseases, abortion(s), domestic abuse, rape/sexual assault, substance (drug and alcohol) abuse and treatment for substance abuse, genetic diseases and genetic testing and test results, mammograms, and HIV/AIDS.

3. Who May Access Information About You, If You Give Consent. Only these people may access information about you: providers in the Tufts MC/NEQCA network, other providers or organizations involved in your care, authorized personnel of these providers or organizations, NEQCA's quality and efficiency medical director and personnel, and others whose job it is to maintain, secure, monitor and evaluate the operation of the Tufts MC/NEQCA HIE.

4. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call your provider's practice.

5. Re-disclosure of Information. Any electronic health information about you may be re-disclosed by your medical care provider and others authorized to access this subset of information to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. If the receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

6. Effective Period. This Consent Form will remain in effect until the day you withdraw your consent.

7. Withdrawing Your Consent. You can withdraw your consent at any time by signing a new Consent Form and choosing to deny consent for your Tufts MC providers, other NEQCA providers, and other providers involved in your care to view your information in the computer network maintained by NEQCA and Tufts MC, and then giving this form to your Tufts MC or NEQCA Provider. By withdrawing your consent you are also choosing to deny consent for your Tufts MC and other NEQCA providers to: (a) share your information with your other providers and organizations involved in your care through other secure electronic means, including but not limited to secure state-wide health information exchange known as the Massachusetts Health Information Highway ("Mass HIway"), and (b) request additional information from your other providers and organizations involved in your care through any secure health information exchange. You can also agree to consent in the future by signing a new Consent Form at any time. You can get the Consent Form from your Tufts MC or NEQCA provider's office. You understand that denying consent will not have an effect on any actions taken prior to such denial.

Note: Providers that are directly involved in your care and other individuals authorized by this Consent Form may access your health information through the Tufts MC/NEQCA HIE while your consent is in effect. Providers that treat you at their Tufts MC or NEQCA practice may copy or include your information in your record in their practice. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

8. Copy of Form. You are entitled to get a copy of this Consent Form after you sign it**.**