

Kern Allergy Medical Clinic, INC  
Tonny Tanus, M.D. Eric J Boren, M.D.  
New Patient Information

*Please Print Clearly*

PATIENT First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Marital Status: M \_\_\_\_\_ S \_\_\_\_\_ W \_\_\_\_\_ D \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \* Required or Credit Card will be ask to be kept on file for billing purposes\*  
Language \_\_\_\_\_ Home Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Preferred Phone (Circle): Home / Cell  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email Address \_\_\_\_\_ Primary Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_ Cross Street \_\_\_\_\_

**Insurance**

<p>Primary Insurance _____ Policy #: _____ Group #: _____ Subscriber Name: _____ DOB: ____/____/____ Social Security _____ - _____ - _____ Relationship to patient: _____</p>	<p>Secondary Insurance: _____ Policy #: _____ Group #: _____ Subscriber Name: _____ DOB: ____/____/____ Social Security _____ - _____ - _____ Relationship to patient _____</p>
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*Please complete if patient is a minor/student*

**Mother (Or Guardian) Information** If Legal Guardian, relationship to patient \_\_\_\_\_  
First Name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last Name \_\_\_\_\_  
SS# \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Ph # \_\_\_\_\_

**Father (Or Guardian) Information** If Legal Guardian, relationship to patient \_\_\_\_\_  
First Name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last Name \_\_\_\_\_  
SS# \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Ph # \_\_\_\_\_

**HIPPA contacts: Authorization to Release Protected Health Information to the following individuals**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

Signature of Patient or Parent/Guardian/Responsible Party

Date

# KERN ALLERGY MEDICAL CLINIC

Tonny Tanus, M.D • Eric J Boren, M.D

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information, for payment or health care operations, in order to provide health care.

We also want you to know that we support your full access to your personal medical records. Written consent will be needed, and your doctors review. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we may have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review privacy notice, to request restrictions and revoke consent in writing, after you have reviewed our privacy notice.

## COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability act (HIPPA) with the particular emphasis on the "Privacy Rule".

It is our policy to properly determined appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of the plan, we have implemented a Compliance Program that will help us prevent any inappropriate use of PHI.

We welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

Print Name. \_\_\_\_\_ Signature: \_\_\_\_\_

Parent, Guardian, (if patient is under 18yrs) or patients

Date: \_\_\_\_\_



Tonny Tanus, MD

Eric J. Boren, MD

Board Certified Adult & Pediatric

### OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician- patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

#### **Patient Registration**

1. A copy of your current insurance card, drivers license and verification of your address is required **at every visit**. You are responsible for ensuring your address and insurance on file are correct. You are responsible for any unpaid balances or fees that arise if this information is not updated.

#### **Cancellations & No Show Policy**

1. Missed appointments not only impact you, but other patients waiting to be seen. If you are unable to keep your appointment, we require 24 hours' notice to cancel so we can open this time up for other patients to schedule. If you do not call within 24 hours you are subject to **\$30** fee for any missed appointment  
**\$50** fee for any missed procedure appointment (Skin Test or Pulmonary Function Test)

#### **Insurance Coverage**

1. As a courtesy, Kern Allergy will verify your coverage and will file insurance claims to your primary and secondary insurance carrier. If the secondary does not cover the balance owed from the primary insurance, you are responsible for any balance on the account.
2. Patients are expected to pay for all estimated co-payments, deductibles, and coinsurances at the time of service. If you are unable to pay your co-pay and any other patient responsibility at the time of service, you will be asked to reschedule.
3. If you have a Deductible exceeding **\$500**, you are required to provide credit card information (*see attached form*). Otherwise services will be paid out of pocket.
4. If our physicians do not participate in your insurance plan, payment in full for your visit is due at the time of your visit.

#### **Insurance Authorizations**

1. It is your responsibility to understand your insurance benefit plan, and to know if a written referral or authorization is required to see the specialist. Often a preauthorization is required prior for procedures. We strongly urge you to contact your insurance company prior to your appointment for detailed benefit coverage, policy limitations, and non-covered service.

#### **Payment**

1. If payment arrangements have not been made with our billing department prior, patients with outstanding balances over *90 days* with any unpaid portions will be billed to your credit card or debit card on file. Appointments will not be scheduled and will not be provided refills until balance is paid in full.
2. A **\$50.00** fee will be charged for any checks returned, along with any bank fees included.
3. If you are requesting a copy of your medical records, there will be a **\$15.00** fee for the first report; **10 ¢** per sheet thereafter.
4. Should you have forms that need to be completed and signed by the Physician you may be subject to a **\$25.00** fee for the first page and **\$5.00** for any additional forms.

**Minor Patients**

1. Patients under the age of 18 must be accompanied by the parent or guardian. *(Unless consented)*
2. The parent who consents for treatment will be the responsible party on the account and is responsible for all charges regardless of divorce or separation decree.
3. We request patients age 18 or older covered under their parent's insurance to sign an authorization allowing Kern Allergy Medical Clinic to contact parents regarding insurance and billing issues.

**Termination/ Discharge from Practice**

The following scenarios may jeopardize the patient/physician relationship in which Kern Allergy Medical Clinic will terminate and discharge the patient from the practice. The patient will be sent a letter of discharge.

- Noncompliance/ Abusive Patient
- Excessive no shows
- Failure to meet financial obligations
- Profanity
- Threats of social media retaliation

I have read and understand Kern Allergy Medical Clinic Financial Policy and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

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Name of Patient (Please Print)

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Signature of Patient or Guardian

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Date



Patient Name: \_\_\_\_\_

Primary doctor: \_\_\_\_\_

Referring doctor: \_\_\_\_\_

### New Patient Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please take time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit:

\_\_\_\_\_

**PATIENT HEALTH HISTORY:** Please check any current and/or past problems.

- Anemia
- Arthritis / Rheumatoid Arthritis \_\_\_\_\_
- Asthma
- Autism
- Autoimmune Disorder/ Lupus/ Epstein Barr/ CVID
- Cancer, if yes please specify which type: \_\_\_\_\_
- Cholesterol
- COPD
- Crohn's Disease
- Diabetes if yes please specify which type: \_\_\_\_\_
- Fibromyalgia/ Multiple Sclerosis
- Hypertension
- Hypothyroidism
- Infections Disease (HIV/TB)
- Migraines
- Psychological/Mental Disorder/ Depression / Anxiety Other: \_\_\_\_\_
- Urticaria/ Dermatitis/ Eczema
- Valley Fever

◆ Are you currently pregnant or expect to become pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

◆ What medications are you currently taking? (Include over-the-counter products, vitamins, and herbal remedies)

\_\_\_\_\_  
\_\_\_\_\_

◆ Have you been hospitalized? Please list approximate dates and reasons:

\_\_\_\_\_  
\_\_\_\_\_

◆ Have you had surgery? Please list approximate dates and reasons:

\_\_\_\_\_  
\_\_\_\_\_

◆ Do you have any medication allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES please list:

**IMMUNIZATIONS:**

◆ Flu shot last received: \_\_\_\_\_ ◆ Covid vaccine? Yes \_\_\_ No \_\_\_ Brand: \_\_\_\_\_ Quantity: \_\_\_\_\_  
(Sept-March)

**WORKPLACE ENVIRONMENT:**

Do you work indoors/outdoors? \_\_\_\_\_ Occupation: \_\_\_\_\_

**FAMILY HISTORY:** (Please indicate family members with any of the following conditions):

Mother Father Brother Sister Other: \_\_\_\_\_  
(specify relationship)

Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Heart Disease (CAD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung/Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma (MI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer (Malignant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ENVIRONMENT/SOCIAL HISTORY:**

Do you have pets at home? Yes \_\_\_ No \_\_\_      What type of flooring is in the home? *Circle all that apply*  
Carpet Tile Laminate Wood Other: \_\_\_\_\_

If YES, please specify type and if they are indoors/outdoors or both:

**SOCIAL BEHAVIOR**

- Smoking Status:       Current       Former       Never
- Vaping e-cigarette       Yes       No
- Passive Smoke:       Yes       No
- HIV Risk:       Yes       No
- Drug Use: \_\_\_\_\_       Yes       No
- Alcohol Use:       Yes       No

◆ Have you had previous allergy testing done thru lab work or skin test? If so please list when and where testing was performed (ex; Quest Diagnostics, PAL, Foundation Lab, LabCorp or doctor's office):

**FOR WOMEN ONLY:**

When was your last Pap smear? (Please list approximate date done- if you've had a Hysterectomy list date of surgery)

When was your last Mammogram? (Please list approximate date)

When was your last Colonoscopy? (Please list approximate date)

**FOR MEN ONLY:**

When was your last Colonoscopy? (Please list approximate date) \_\_\_\_\_