What's Pollenating?

Our clinic collects pollen samples from two specific locations, providing accurate and current information about local pollens. You can check it out on our website at www.BellinghamAllergy.com.

We also report daily to the Bellingham Herald.

Exciting News!!

Peanut desensitization is here! We are successfully desensitizing kids who are peanut allergic, and we are soon to embark on desensitizing more foods including milk, egg and tree nuts.

Clinical Research

Our Clinical Research Center has been in full operation since 1994. We conduct pharmaceutical-sponsored clinical trials in the areas of asthma and COPD, chronic cough, allergies and chronic sinusitis, nasal polyps, atopic dermatitis and urticaria. (hives)

We earnestly strive to adhere to all FDA regulations & maintain Good Clinical Practices.

Please ask how you can get involved in our studies!

Billing Information

We are contracted with most major insurance companies and will bill your insurance company if we have the appropriate billing information. Please bring your insurance card and photo ID.

Our office policy is to collect deductibles, co-insurance and co-payments at the time of service. Our bookkeeping department will check on your benefits prior to your appointment. If you do not hear from us please give us a call.

Full payment is required if you do not have insurance coverage. A 30% discount is offered to private pay patients when paid at the time of service. If this is not possible, you may be able to make payment arrangements with our bookkeeping staff. We do accept Visa, Mastercard and Discover for your convenience.

Insurance coverage is an agreement between you and your insurance company. Responsibility for payment rests with you, regardless of your coverage. We cannot accept responsibility for collecting your claim or for negotiating settlement on a disputed claim.

A service charge will be imposed on any balance over 60 days. If at that time specific payment arrangements have not been made, collection proceedings will begin.

For patients whose parents are divorced or in a state of family change, the parent who initiates treatment for the child is responsible for payment.

Feel free to call with any questions or stop by our bookkeeping department when you are in the office.

Bellingham Asthma, Allergy & Immunology Clinic

Patient Information

3015 Squalicum Parkway, Suite 180
Bellingham, WA 98225
Tel. (360) 733-5733 Fax (360) 733-1859
www.BellinghamAllergy.com

Office Hours

Monday 8:30-5:30

Tuesday 8:30-5:30

Wednesday 8:30-5:30

Thursday 8:30-5:30

Friday Closed

Allergy Shot Hours

Monday 9:00-5:00

Tuesday 9:00-6:00

Wednesday 9:00-5:00

Thursday 9:00-6:00

Friday Closed

About our Office

Bellingham Asthma, Allergy & Immunology Clinic was founded in 1988. We provide expert care to those with the diagnosis and management of asthma, chronic cough, respiratory allergies, chronic rhinitis, sinusitis, eczema, and related skin problems, food & insect allergies, medication allergies, hives, recurrent infections and immunodeficiency problems.

Our Providers

David Elkayam, MD is board certified in Allergy and Immunology and Pediatrics. He is a graduate of the Mt. Sinai School of Medicine in New York. Dr. Elkayam served as Chief Resident in Pediatrics at the University of Colorado Health Sciences Center and acquired his fellowship in Allergy and Immunology at the National Jewish Center (NJH) for Immunology and Respiratory Medicine in Denver, Colorado.

Andrew Parker, MD is board certified in Allergy and Immunology. He is a graduate of Temple University School of Medicine in Philadelphia. He completed his residency training in Internal Medicine at the Beth Israel Deaconess Medical Center/Harvard Medical school in Boston and acquired his fellowship in Allergy & Immunology at the University of Washington and Seattle Children's Hospital.

Martha Serven PAC is a Nationally Certified Physician Assistant. Martha did her undergraduate work at Washington University in St. Louis and her physician assistant training at the Medex Program at the University of Washington in Seattle. She has been with us since April 2000, and has over 12 years experience in Family Medicine.

Our newest provider **Katie Anderson, MPAS, PAC,** is a Nationally Certified Physician Assistant. Katie did her undergraduate work at Colorado State University and received her Masters in physician assistant studies at Chatham University in Pennsylvania. She comes to us from New Mexico where she has worked in primary, urgent and emergency care the past 6 years. She joined our team May 2019.

Both fully licensed Physician Assistants work under the direct supervision of David Elkayam, MD and Andrew Parker, MD and have full prescribing ability.

Your Initial Visit

Please fill out, and bring with you, the new patient history form that is included in your packet. **Plan on your first visit lasting up to 3 hours.** During this time, we will obtain a comprehensive history and physical exam. In addition, skin testing, pulmonary function testing, lab and x-ray work may be ordered to establish a diagnosis and treatment plan. **The average fees for this appointment may range from $350-$1200.** Lab and x-ray work is billed separately from our office billing.

We will discuss your evaluations and tests and outline a course of treatment. Your treatment may consist of medications, environmental controls and/or allergen immunotherapy (allergy shots).

In Preparation for your Initial Visit……

Allergy skin testing may be included in your initial visit. To not compromise the accuracy of the skin testing, we ask that you **stop antihistamines**, including cold and allergy medications and OTC sleep aids at least 5 **days before your appointment**. **Continue all other medications**. Please call our office if you have any questions.

Please call 24-hours in advance to cancel or reschedule appointments. You will be charged a $50 no-show fee for appointments that are not cancelled or rescheduled 24-hours prior to the visit. This charge is not covered by insurance.

Because we need to see acutely ill patients, we occasionally run behind schedule. Your time is important to us; do not hesitate to call on the day of your appointment to confirm your appointment time.

If required by your insurance, please obtain a written referral from your primary care doctor prior to you first visit. Call our office if you need assistance.

Medication Refills

Contact your pharmacy for any prescription refills.

Emergencies

For an emergency, contact 911 or have someone take you to the emergency room. If your problem is less urgent, call 733-5733 during office hours.

After office hours, please call 715-2419 and the provider on-call will be paged. Be prepared to identify yourself and to review your problem.

042019

Bellingham Asthma, Allergy & Immunology Clinic
New Patient Demographic Information

Patient Last Name _____First _____Middle_____Date of Birth _____/_____/_____Age_____

Gender Identity (Check **ALL** that apply) ☐ Male ☐ Female ☐ FTM ☐ MTF ☐ Other (please specify) _____

What sex were you assigned at birth? (check one) ☐ Male ☐ Female ☐ Other Preferred Pronoun_____

Primary Phone Number_____ ☐ Home _____ ☐ Cell _____ ☐ Work _____

Secondary Phone Number_____ ☐ Home _____ ☐ Cell _____ ☐ Work _____

Other Phone Number_____ ☐ Home _____ ☐ Cell _____ ☐ Work _____

Mailing Address _____Apt #_____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Social Security Number _____

Marital Status (circle one) S W M D Email Address_____

Spouse Name_____ Spouse Employer _____ Spouse Phone _____

Medical Insurance	**Primary**	**Secondary**
Insurance Co	_____	_____
Subscriber Name/DOB	_____/_____	_____/_____
Group #	_____	_____
ID #	_____	_____

How did you hear about our clinic? **(circle one)** Phone Book Newspaper Internet Friend Radio Family Provider

Primary Care Provider: _____Referring Provider _____

Please list a local relative or friend for an emergency contact:

_____

Name Relationship to patient Phone number

Please complete the following information if the patient is under 18 years old or if you are insured under a parent:

Father's Name_____ Birthdate_____ SS#_____

Home address_____ Home/Cell Phone_____

Employer_____ Work Phone_____

Mother's Name_____ Birthdate_____ SS#_____

Home address_____ Home/Cell Phone_____

Employer_____ Work Phone_____

We will assist you in billing your insurance if you bring in your insurance card(s) at the time of your visit. If you fail to attend an appointment without canceling 24 hours in advance, you will be charged a no-show fee. I hereby authorize Bellingham Asthma & Allergy to release to my primary and secondary insurance company any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at Bellingham Asthma & Allergy. I hereby agree to full responsibility for all expenses incurred by myself or my child.

Signature _____ Date _____

***** Please fill out both sides of this form *****

BELLINGHAM ASTHMA, ALLERGY & IMMUNOLOGY CLINIC
PATIENT HISTORY

David Elkayam, MD Andrew Parker, MD Martha Serven, PA-C Katie Anderson, MPAS, PA-C

Date of appointment_____

Patient's Name_____ **Birth Date**_____ **Age**_____

Primary Physician_____ **Referred by**_____

Preferred Pharmacy_____ **Preferred Language:** English___Spanish_____Other _____

Race: American Indian/Alaska Native____Black/African American ____Native Hawaiian____White____Asian___Other_____

Ethnicity: Hispanic or Latino_____Not Hispanic or Latino_____ **(Race & Ethnicity are needed for lung function testing.)**

If you need help in completing this questionnaire, please arrive 30 minutes early to your appointment and let our staff know. We will gladly assist you.

What's the main reason why you came to see the doctor today?_____

_____

When did your symptoms begin? _____

What are your goals for this visit?_____

_____

Do you miss work/school because of your symptoms? If so, how often? _____

CURRENT MEDICATIONS: Please bring to the office or list below all medications you are currently taking:

List Name and Dosage

1-_____ 4-_____

2-_____ 5-_____

3-_____ 6-_____

Do you have any allergies to medications? Y___N___

IF YES: Medication What was your reaction?

_____ _____

_____ _____

_____ _____

Have you had a reaction to Penicillin? Y___N___ **Would you like to be tested?** Y___N___

Presenting Illness: ***(To be completed by nurse of physician)***

OTHER ALLERGIES

- Do you have a **food allergy**? Y____ N____*If yes, to what food (s)?*

☐ _____	☐ Hives	☐ GI/Intestinal	☐ Anaphylaxis
☐ _____	☐ Hives	☐ GI/Intestinal	☐ Anaphylaxis
☐ _____	☐ Hives	☐ GI/Intestinal	☐ Anaphylaxis
☐ _____	☐ Hives	☐ GI/Intestinal	☐ Anaphylaxis

- Have you ever had **eczema (atopic dermatitis)? …… Y____N_____**
- Have you ever had a **severe bee sting** reaction**? …….. Y____N_____**
- Do you have **recurrent hives and / or other swelling? …….. Y____N_____**
- Do you have an **allergy to rubber latex products** (e.g. balloons, rubber gloves etc.) **Y____N_____**
- Have you had allergic reactions **to Aspirin, Ibuprofen, Aleve?.....Y____N_____**
  If yes, what are your symptoms _____

ALLERGY & ASTHMA SECTION

Do you have problems with any of the following: (check which apply) *Otherwise, please skip to next section*

Ear, Nose & Throat			Breathing
___Sneezing	___Eye Tearing	___Sore Throat	___Cough
___Itchy Nose	___Itchy Eyes	___Hoarseness	___Dry ___Wet___Sputum/phlegm
___Nasal Congestion	___Eye Redness	___Sleep Apnea	___Constant tickle or glob in throat
___Mouth Breathing	___Eye Swelling	___CPAP Machine	___Day___Night___Both
___Runny Nose	___Post Nasal Drainage	___Headaches	___Triggers:_____
___Ear Aches	___Sinus Infections:		___Wheeze
___Itchy Ears	Frequency:_____		___Shortness of Breath
___Ear Infections			___Chest Congestion
Frequency:_____			___Chest Tightness
___Ear Blockage			___Chest Pain
			___Allergies trigger asthma
			___Which:_____

- Do you experience allergy symptoms:___Year Round___Seasonally
- Which months of the year are most bothersome? Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Have you been diagnosed with Asthma? Yes / No (*If no, skip to the next section.)*

- Have you ever been to Urgent Care, the ER or hospitalized for asthma? _____
- When was your last hospitalization for asthma?_____
- Have you ever taken oral steroid medications (Prednisone, Prelone, Pediapred) for treatment of asthma?…… Y___N_____

PREVIOUS EVALUATIONS

- Have you ever had **allergy skin tests**? Y____N____When? _____
  If yes, what were you allergic to: _____
- Previous IT (Allergy Shots): Where_____When_____
- Have you ever had a **chest X-ray/CT**? Y____ N___Date_____**sinus X-ray**? Y____ N___Date_____
  sinus CT scan? Y___N_____Date_____

REVIEW OF SYSTEMS:

General	Skin	Cardiovascular	Gastrointestinal	Urinary	Musculoskeletal
__Fever __Sweats __Chills __Unwell __Fatigue __Difficulty Concentrating	__Itching __Scaling __Dry Skin __Rashes	__Chest Pain __Irregular Heart Beat __Lower leg/ankle Swelling __Congestive Heart Failure __Murmur	__Difficulty Swallowing __Nausea __Vomiting __Heartburn/GE Reflux __Treated? __Burps __Cramping __Constipation __Diarrhea	__Painful Urination __Bladder Control Problems __Incontinence	__Aching Joints __Swollen Joints __Aching Muscles __Muscle Weakness

Neurologic	Psychiatric	Endocrine	Hematologic
__Numbness __Tingling __Headache	__Depression __Anxiety __Panic Episodes __Trouble Falling Asleep __Trouble Staying Asleep	__Thyroid Trouble __Heat/Cold Intolerance __Excessive Sweating __Excessive hunger/thirst __Excessive Urination	__Anemia __Easy Bruising __Past Transfusions

YOUR PERSONAL MEDICAL HISTORY:

___Cancer Type_____Treatment_____ Year_____
___Gastro-intestinal Problems (Stomach Problems)
___Heart Disease
___Irritable Bowel Disease/ Colitis
___Irritable Bowel Syndrome
___Diabetes
___Arthritis
___High blood pressure
___Celiac Disease (Gluten Sensitivity)
___GE Reflux
___Thyroid Disease
___Psychological problems
___Depression
___Other medical problems:

VACCINE HISTORY:

___COVID Vaccine_____1st Dose Date: _____ 2nd Dose Date: _____
___Flu Vaccine (this year)_____ Date: _____
___Pneumonia Shot_____Date: _____

OPERATIONS AND/OR HOSPITALIZATIONS:

Procedure:	**Year:**	**Procedure:**	**Year:**

FAMILY HISTORY: Do people in your family have any of the following; (parents, siblings, children, grandparents)

Asthma_____ COPD/Emphysema_____ Bronchitis_____
Seasonal Allergies_____ Food Allergies _____ Eczema_____
Medication Allergies_____ Sinus problems_____ Glaucoma_____
Heart disease_____ High blood pressure_____ Thyroid Disease_____
Arthritis_____ Cancer _____
Diabetes_____ Colitis, chronic diarrhea_____
Frequent or Unusual Infections_____

Other medical problems_____

FOR CHILDREN ONLY:

Birth weight:_____Breast-fed? Y___N____How long?_____Colic? Y___N____Vomiting? Y___N___

Diarrhea? Y___N____Rash? Y___N____

When were solid foods introduced?_____Any dietary restrictions? Y____N____

Immunization status: Up to Date / Not up to date Any severe reactions?_____

Day care?_____How many days per week_____

Does child spend time in an alternate/additional living environment (i.e., divorced parents)?

SMOKING HISTORY

Have you ever smoked? Y N **Do you currently smoke?** Y N

- How many years have you smoked?_____ How many packs per day? _____
- How many packs per year? _____
- What age did you start?_____. If you have stopped smoking, what age did you stop?_____
- Are there any smokers in the home or car? Y___ N___

Have you ever vaped? Y N **Do you currently vape?** Y N

ENVIRONMENTAL REVIEW

(Please "X" those that apply to your home environment)

How long have you lived in the Pacific Northwest? _____
Where did you live previously? _____

Home:____city ___county What is the age of your home_____.

Is your home: dry damp If *damp*, where?_____
Do you have: mold /mildew If so where? _____

Type of heating / ventilation system?

__furnace forced air (__gas / __oil /__electric) furnace air filter (_none_regular_HEPA)
__baseboard electric wood / pellet stove

Type of floor covers:____wood_carpet / rugs:_old_new_carpet over concrete slab in basement or lower level?

Do you use: ___gas fireplace fireplace humidifier vaporizer ___room size air filter (e.g., HEPA)

Pets: Do you have pets? Y ___ N If so, how many? cats_____, dogs_____, Other _____
Do your pets spend time indoors? Y___ N In patient's bedroom? Y N

Do any of the following worsen your Asthma or Allergies:

___House dust (mites)	Spring/Summer Pollens	Exercise
___Other dusts (wood, barn, etc.)	Wind	Paint / fumes
___Moldy areas	Weather changes	Perfume
___Cats or___Dogs	Rain / dampness	Respiratory infections (colds)
___Other Animals	Heating / ventilation	Anxiety / stress
___Flowers	Air conditioning	Smoke (tobacco/ wood / kerosene)
		___Other: _____

- Are your symptoms worse at:____Home____Work____Day____Night

Current occupation:_____ What are your hobbies? _____

Have you have any unusual chemical or dust exposures? Y___N *if yes:*_____

BELLINGHAM
Asthma & Allergy

Request for Confidential Communication
of Personal Health Information

Patient name _____

Communication between this office and the above patient can be handled in the following manner(s):

By Telephone to: Home_____ Work_____ Cell Phone_____

Home # _____ Work # _____ Cell # _____

OK to Leave Message: _____ Home _____ Work _____ Cell phone

_____ With Family Member

This communication may include, but is not limited to confirming appointments, lab/X-ray results, and appointment follow-up, prescriptions and bookkeeping issues Please note that communication over cellular phones have the potential to be over heard.

I consent to receive calls from Bellingham Asthma, Allergy & Immunology Clinic for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

If there are any family members or friends that you would like us to be able to discuss your condition, lab results, test results etc., over the phone or in any other way when you are not present, please list their names and relationship to you here.

Besides your medical providers, you give our office permission to communicate with:

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

_____
Your Signature or legally authorized individual

_____
Printed name if legally authorized to sign on behalf of patient Relationship

_____
Date

****** Please fill out both sides of this form *** ***