Michael T. Mosher, MD, FACAAI Diplomate of the American Board of Allergy and Immunology
415 E. Rolling Oaks Dr. #280, Thousand Oaks, CA 91361 / 2876 Sycamore Dr. #301, Simi Valley, CA 93065 (805) 496-8522 fax (805) 267-9832

PATIENT ALLERGY HISTORY:

PATIENT NAME: _____ DOB: _____

TODAY'S DATE: _____

THE REASON I AM SEEING THE DOCTOR TODAY IS: _____

_____

OTHER MEDICAL PROBLEMS: _____

_____

_____

PRIOR SURGERIES: _____

_____

MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, VITAMINS, HERBAL): _____

_____

_____

DRUG ALLERGY? [ ] NO [ ] YES (What drug? When? Describe reaction) _____

_____

FOOD ALLERGY? [ ] NO [ ] YES (List foods, Describe reactions) _____

_____

SMOKING: [ ] NEVER [ ] YES, CURRENT [ ] YES, PAST _____

SIGNIFICANT EXPOSURE TO SECONDHAND CIGARETTE SMOKE? [ ] NO [ ] YES _____

IMMUNIZATIONS: NORMAL CHILDHOOD IMMUNIZATIONS [ ] NO [ ] YES [ ] ANNUAL FLU SHOT [ ] PNEUMOVAX

WHAT TYPE OF PETS DO YOU HAVE AT HOME?_____

OTHER PET EXPOSURES:_____

WHO IN YOUR IMMEDIATE FAMILY HAS ALLERGIES OR ASTHMA:_____

PRIOR ALLERGY TESTING? [ ] NO [ ] YES PRIOR ALLERGY SHOTS? [ ] NO [ ] YES _____

_____

Review of systems: If you experience any of the symptoms listed below, please circle

General:	Fever, Sweats, Fatigue, Change in weight
Skin:	Rash, Itching, Dry skin
Head:	Dizziness, Headaches
Eyes:	Change in vision, Red eyes, Itching, Irritation, Discharge, Cataracts
Ears:	Difficulty hearing, Ringing, Pressure, Popping, Pain
Nose:	Stuffy nose, Sneezing, Itching, Dripping, Decreased smell, Snoring
Throat:	Hoarse voice, Sore throat
Neck:	Thyroid problem, Lumps or "swollen glands"
Chest:	Pain, Shortness of breath, Cough, Wheeze, Chest tightness or heaviness
Heart:	Pain, Palpitations, Heart murmur, History of heart attack
GI:	Decreased appetite, Nausea, Vomitting, Diarrhea, Heartburn, Abdominal pain
Rheum:	Joint pain, Joint stiffness, Arthritis, Back problems
Neurologic:	History of stroke, Loss of memory, Psychiatric disorder, Numbness, Weakness
Heme/Onc:	History of anemia, History of cancer

Michael T. Mosher, MD, FACAAI
A Medical Corporation

Diplomate of the American Board
of Allergy and Immunology

Patient Registration:

Patient Last name:_____ First name_____ MI:_____

Birthdate:_____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Address:_____ City:_____Zip:_____

Home phone:_____Cell phone:_____Work Phone:_____

Email:_____

Social Security #:_____ Calif Driver's Lic :_____

Employer:_____ City:_____

Friend/relative for emergency Contact:_____Phone:_____Relationship:_____

WHO REFERRED YOU?:_____

PATIENT'S PRIMARY CARE PHYSICIAN:_____City_____Phone_____

PARENT'S – SPOUSE –INFORMATION

Relation to Patient: ____Spouse ____Parent ____Child ____Other

Soc.Sec No._____Driver's Lic#_____State_____Birthdate_____

Last Name:_____First:_____Mi._____Home Phone:_____

Address:_____City:_____Zip:_____

Employer:_____City: _____Work Phone:_____Cell Phone:_____

INSURANCE INFORMATION:

Primary Insurance Holder's Name_____

Relationship To Patient_____Birthdate_____

PRIMARY INSURANCE COMPANY: _____ID#_____

SECONDARY INSURANCE COMPANY:_____ID#_____

I, THE UNDERSIGNED, AUTHORIZE PAYMENT BY THE ABOVE NOTED INSURANCE COMPANY(S) BE MADE DIRECTED TO MICHAEL T. MOSHER, MD FOR ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY SAID INSURANCE, INCLUDING DEDUCTIBLE AND COPAYMENTS. I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I FURTHER AGREE IN THE EVENT OF NONPAYMENT OF ANY AMOUNTS DUE BY ME, TO BEAR THE COST OF COLLECTION, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED. IF PATIENT IS A MINOR, AS PARENT AND/OR GUARDIAN, I HEREBY AUTHORIZE PHYSICIANS OF MICHAEL T. MOSHER, MD., A MEDICAL CORPORATION, TO TREAT MY CHILD.

SIGNED:_____ Date:_____

I, (print)_____have received a copy of this office's Notice of Privacy Practices.

SIGNED:_____ Date:_____