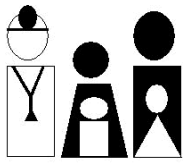


Healthy. Together.

Eugene W. Tsai, MD APMC
Offices of Dr. Tsai and Dr. Jerome
12291 Washington Blvd, Suite 105, Whittier, CA 90606
1360 W. 6th St, Suite 310, San Pedro, CA 90732
3801 Katella Avenue, Suite 222, Los Alamitos, CA 90720
Ph: (310) 241 - 0822 or (562) 594 - 8831
Website: www.sanpedroallergy.com or www.losalamitosallergy.com

LIST OF FORMS

1)New Patient Form (print and fill out)
2) Introduction Letter (read only)
3)HIPAA Consent Form (print and fill out)
4)Environmental, Social, Family History Form (print and fill out)

Please bring the New Patient Form, HIPAA Consent Form, Environmental, Social, Family History Form, and your insurance card to your appointment with Dr. Tsai or Dr. Jerome.

Thank you.

NEW PATIENT INFORMATION RECORD

Patient_____

First Name Middle Name Last Name

Marital Status: □Single □Married □Widowed □Other_____

Gender: □ Male □Female Age_____

Address_____

City_____ Zip Code_____ Birth Date_____

Phone Number ( )_____Cell ( )_____

Email_____

INSURANCE INFORMATION

Name on Insurance Card:_____

First Name Middle Name Last Name

Relationship to Patient: □Self □Parent □Spouse □Other_____

Birth Date:_____

Referred By:_____

(name of the physician or referring person)

Friend or Relative to Contact in Case of Emergency:_____

Relationship to Patient:_____

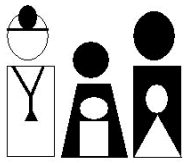
Phone Number: ( ) _____Cell ( )_____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize Eugene W. Tsai, MD, APMC to disclose when requested by the above named insurance carrier of its representatives any and all information with respect to any illness(es) of injury(ies), medical history, or treatment and copies of all medical records. A photographic copy of this authorization shall be considered as effective and valid as the original.

I hereby authorize payment directly to Eugene W. Tsai, MD, APMC of the surgical and /or medical benefit if any, otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for the charges not covered by this authorization. I further agree in the event of non-payment to bear the cost of reasonable legal fees should this be required.

Date_____ Signature_____



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INTRODUCTION LETTER

Dear Patient or Parent,

We look forward to meeting you at your first visit. For new patients, we like to spend the appropriate amount of time needed to understand your problems with allergy, asthma, or immunology and to explain options for diagnosis and treatment. Your first visit with us will usually last 45 to 90 minutes depending on the complexity of your case. So, please be sure to allow enough time in your schedule for this consultation. If you need to reschedule your appointment with us, as a courtesy, please notify our office 24 hours in advance of your scheduled appointment.

In our office, we perform allergy testing. We schedule allergy testing during a follow up visit AFTER a patient's first visit with us if it is determined that allergy testing is needed. We prefer to spend the time during the first visit to carefully assess your condition and discuss options for further diagnosis and treatment.

For more information about our office, you can visit us at www.losalamitosallergy.com or www.sanpedroallergy.com.

Sincerely,

Eugene W. Tsai, MD & Dennis C. Jerome, MD

Environmental, Social, and Family History

Environmental Survey

What city or cities does the patient live in? _____
Patient lives in a (house, condo, apartment, or other _____). Please circle one.
How old is your home? (less than 10 years old, between 10 to 25 years old, older than 25 years old). Please circle one. How many years has the patient been living there?_____
What type of flooring do you have (hardwood, laminate, carpet, rugs, tile). Please circle all that apply. For patients with carpeting, how old are your carpets?_____
What type of pets do you have? _____
Does patient smoke? Yes No If yes, how many packs per day _____
Does anyone in the family smoke? Yes No Has patient ever smoked? Yes No
Does patient have their own bedroom? Yes No If no, how many people share? ____

Social History (fill out for patients older than 6 years of age)

What does patient do for a living or what grade in school? _____
What does patient do in their spare time or hobbies? _____
What does patient do for exercise ?_____
Any recent foreign travel in the past 12 months? _____

Social History (fill out for patients less than 5 years of age)

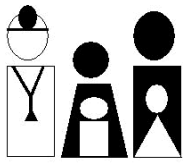
Does your child attend daycare? Yes No (please circle) Do any of your other children attend daycare? Yes No (please circle) What type of formula did your child use in their first year of life? _____At what age did you introduce solid foods to your child? _____At what age did you introduce cow's milk to your child?_____
List any foods that your child avoids because of allergies?_____

Family History

Does anyone in your family have nasal allergies, asthma, or eczema? Yes No
What type of medical problems run in the family?_____

Drug Allergy

Do you have any allergies to medications? Yes No If Yes, which ones _____
_____



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HIPPA PATIENT CONSENT FORM

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to receive our notice before signing the consent. The terms of our notice may change. If we change notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclose for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for your treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:
1) Protected health information may be disclosed or used for treatment, payment, or healthcare operations
2) The practice has a Notice of Privacy Practice and that the patient has the opportunity to review this notice.
3) The Practice reserves the right to change the notice of privacy practices.
4) The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6) The practice may condition receipt of treatment upon the execution of this consent.

This Consent was signed by:	Signing of Consent was witnessed by:
_____	_____
Printed Named-Patient or Representatives	Physician
_____	_____
Patient or Representatives Signature	Signature of Physician
_____	_____
Date	Date