ALLERGIC DISEASE ASSOCIATES, P.C.

Date: ____________________

Sec. Initial:

☐ BROAD STREET ☐ PINE STREET ☐ NE PHILADELPHIA ☐ BALA CYNWYD ☐ LANGHORNE ☐ MOUNT LAUREL ☐ WOODBURY ☐ HAMILTON ☐ FORKED RIVER

Social Security No.______________________ Sex: ☐ Male ☐ Female Birthdate:______________

PATIENT NAME: (Last)______________________ (First) ______________________
ADDRESS: (Street)______________________
(City)______________________ (State)______________________(Zip) __________
Contact Phone #s for Protected Health Information: Home:______________________ Daytime: ______________

Emergency Contact Name ______________________Phone No.: ______________

Family Physician: ______________________ ☐ MD ☐ DO______Phone No.: ______________
Address:______________________(City) ______________(State) __________ (Zip)__________

Referring Physician: ______________________ ☐ MD ☐ DO______ Phone No.: ______________
Address:______________________(City) ______________ (State) __________(Zip) __________

Consent for communication on you or your child's case with your physician(s) ☐ Yes ☐ No

How did You Hear About Our Practice? (Check All That Apply)

M.D. Initial:

☐ Newspaper ☐ Radio ☐ Friend ☐ Relative ☐ Insurance Directory ☐ 1-800-4-POLLEN ☐ Yellow Pages ☐ Physician
☐ Other: ______________________

PRIMARY INSURANCE

Who is named as the policyholder on the patient's insurance?______________________
Patient is: ☐ Self ☐ Spouse ☐ Child ______________________
If child, list parent's full name
Policyholder birthdate:__________ Policyholder S.S. # ______________________

PLACE OF EMPLOYMENT OF POLICYHOLDER ______________________ Phone No.:______________
Insurance Company Name:______________________
Address: ______________________
City:______________________State:__________Zip: ______________Phone No.: ______________
Insurance #'s: Group #______________________I.D. #______________________

SECONDARY INSURANCE

Does the patient have any other insurance? ☐ Yes ☐ No
Who is named as the policyholder on the patient's secondary insurance? ______________________
Patient is: ☐ Self ☐ Spouse ☐ Child
Policyholder birthdate:__________ Policyholder S.S. # ______________________

PLACE OF EMPLOYMENT OF POLICYHOLDER ______________________ Phone No.: ______________
Other Insurance Company Name:______________________
Address: ______________________
City: ______________________State: __________ Zip: ______________Phone No.: ______________
Insurance #'s: Group # ______________________ I.D. #______________________

Interest of 1.5% per month will be charged on all unpaid balances of 30 days or more.

Medicare Patients:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Allergic Disease Associates, P.C.** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits of related services.
I have received a copy of the Allergic Disease Associates, P.C. Practice Policies.

Signature______________________

Commercial Insurance Patients:

I authorize the release of any medical information necessary to process all claims and I authorize payment of medical benefits to **Allergic Disease Associates, P.C.** for services rendered. It is our policy, and the policy of your insurance company, that all *co-payments* be paid at the time of medical service. There will be a $10 billing charge for each co-payment not paid at time of service.
I have received a copy of the Allergic Disease Associates, P.C. Practice Policies.

Signature______________________

PLEASE CHECK THAT YOU HAVE COMPLETED THIS FORM

090810

New Patient Allergy History & Review of Systems

The Asthma Center

Patient name: ______________________ DOB: ______________________

What is the major reason for this allergy consultation? Check all that apply.

- ☐ Hayfever or sinus symptoms
- ☐ Drug reaction
- ☐ Hives or swelling
- ☐ Recurrent infections
- ☐ Insect-sting reaction
- ☐ Asthma or chronic cough
- ☐ Food allergy
- ☐ Headaches
- ☐ Eye problems
- ☐ Intestinal problem
- ☐ Eczema or other rash

Other (explain below):

____

____

____

When did your symptoms begin? ______________________

Symptom frequency: ☐ Less than twice/wk ☐ 3 or more days/wk ☐ Every day ☐ More than 2 nights/wk

When are you symptomatic? WINTER SPRING SUMMER FALL YEAR-ROUND

Where are symptoms the worst? INDOORS OUTDOORS

When are symptoms the worst? WINTER SPRING SUMMER FALL YEAR-ROUND

Have you ever been allergy skin tested? ☐ YES ☐ NO If yes, when?______________________

Have you ever tried any medications for your symptoms? ☐ YES ☐ NO If yes, which?______________________

Family history

Mark with an [x] and explain if answer is "other"

	Asthma	Allergies	Other (explain)
Father			
Mother			
Brother(s)			
Sister(s)			

Have you ever been diagnosed with any of the following allergies?

Chemical	☐NO	☐YES	Date:__________
Drug	☐NO	☐YES	Date:__________
Food	☐NO	☐YES	Date:__________
Metals	☐NO	☐YES	Date:__________
Seasonal	☐NO	☐YES	Date:__________
Animal dander	☐NO	☐YES	Date:__________
Dust	☐NO	☐YES	Date:__________
Mold	☐NO	☐YES	Date:__________
Freshly cut grass	☐NO	☐YES	Date:__________

Name:_______________________________ DOB:________________

New Patient Allergy History Form

Occupational exposure(s)

Describe your type of work or daily activity.

____
____
____

☐ Office setting ☐ Outdoor setting ☐ Homemaker ☐ School (Grade: ____)

Are symptoms affected by work or school? ____

Social history

Smoking: NO ACTIVE/FORMER Packs/day:__________ Year quit:_________ # of years smoked:____________

Current passive smoke exposure: NO YES # of years:____________

Past passive smoke exposure: NO YES # of years:____________

Alcohol: None Daily Social Abuse

Illicit drug use: NO YES

Nasal drug abuse: NO YES

Over-the-counter nasal sprays: NO YES If yes, for how long:______________________

(e.g. nasal decongestant sprays such as Afrin)

Hobbies:____

Please note any other history that you feel the doctor/nurse should know about you. If appropriate, note any stress or emotional problems that might affect your symptoms.

Patient name:____

DOB:______________________

The Asthma Center

Review of Systems

Please check 'YES' or 'NO' regarding the following symptoms:

General

Recent weight change	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Good general health lately	☐ YES	☐ NO
Had a pneumonia shot?	☐ YES	☐ NO
Had a flu shot?	☐ YES	☐ NO
Chest x-rays	☐ YES	☐ NO

If yes, date* :__________________Ordered by:__________________________ Where:________________________

Sinus x-rays / CT scan ☐ YES ☐ NO

If yes, date* :__________________Ordered by:__________________________ Where:________________________

Laboratory studies ☐ YES ☐ NO

If yes, date* :__________________Ordered by:__________________________ Where:________________________

***If the study, x-ray or scan has been performed in the last 12 months, please bring a copy of the report to your appointment.**

Have you been seen by:

Allergist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
Cardiologist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
Dermatologist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
Endocrinologist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
ENT	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
Gastroenterologist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
Pulmonologist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
Rheumatologist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________
Neurologist	☐ YES	☐ NO	If yes, Date:_________	Physician Name:____________________________

Have you had:

Cancer	☐ YES	☐ NO
Other serious or chronic medical problems	☐ YES	☐ NO
Surgery	☐ YES	☐ NO

If yes, Date:__________________ Type:_________________Where:________________________

Date:__________________ Type:_________________Where:________________________

Date:__________________ Type:_________________Where:________________________

Date:__________________ Type:_________________Where:________________________

Date:__________________ Type:_________________Where:________________________

Allergic/Immunologic

Hayfever	☐ YES	☐ NO
Eczema	☐ YES	☐ NO
Urticaria (hives)/angioedema	☐ YES	☐ NO

Review of Systems

Fungal infection	☐ YES	☐ NO
Contact dermatitis	☐ YES	☐ NO
Metal allergy	☐ YES	☐ NO
Poison ivy allergy	☐ YES	☐ NO
Psoriasis	☐ YES	☐ NO
Other rash	☐ YES	☐ NO
Frequent or serious infections	☐ YES	☐ NO
Frequent sinusitis	☐ YES	☐ NO
Problems with local/general anesthesia	☐ YES	☐ NO
Slow to heal after cuts	☐ YES	☐ NO

Eyes and vision

Wear contact lenses	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Watery eyes	☐ YES	☐ NO
Dry eyes	☐ YES	☐ NO
Red eyes	☐ YES	☐ NO
Dark circles around eyes	☐ YES	☐ NO
Sensitivity to light	☐ YES	☐ NO
Blurred or double vision	☐ YES	☐ NO
Swelling around eyes	☐ YES	☐ NO
Eye discharge	☐ YES	☐ NO
Glaucoma/cataracts	☐ YES	☐ NO
Eye pain or irritation	☐ YES	☐ NO
Eye disease or injury	☐ YES	☐ NO
Failing vision	☐ YES	☐ NO
Other eye diseases: ____________________	☐ YES	☐ NO

Ear, nose, throat

Bleeding gums	☐ YES	☐ NO
Bad breath or bad taste	☐ YES	☐ NO
Mouth sores	☐ YES	☐ NO
Swollen glands in neck	☐ YES	☐ NO
Ringing in the ears (tinnitis)	☐ YES	☐ NO
Earaches or drainage	☐ YES	☐ NO
Ear popping	☐ YES	☐ NO
Hearing loss	☐ YES	☐ NO
History of tubes in ears (myringotomy)	☐ YES	☐ NO
Difficulty swallowing	☐ YES	☐ NO
Ear itch	☐ YES	☐ NO

Review of Systems

Nose itch	☐ YES	☐ NO
Sneezing	☐ YES	☐ NO
Nasal congestion/blockage	☐ YES	☐ NO
Runny nose	☐ YES	☐ NO
Nose bleeds/epistaxis	☐ YES	☐ NO
Dry nose	☐ YES	☐ NO
Nasal discharge If yes, discoloration? ☐ YES ☐ NO	☐ YES	☐ NO
Snorting/grimacing	☐ YES	☐ NO
Loss of or no sense of smell	☐ YES	☐ NO
Sinus problems	☐ YES	☐ NO
Sinus pressure	☐ YES	☐ NO
Decreased sense of smell	☐ YES	☐ NO
Mouth-breathing	☐ YES	☐ NO
Snore/apnea	☐ YES	☐ NO
Sinus headache/sinus pressure	☐ YES	☐ NO
Number of sinusitis episodes per year: __________		
Itchy throat	☐ YES	☐ NO
Sore throat	☐ YES	☐ NO
Post-nasal drip	☐ YES	☐ NO
Throat-clearing	☐ YES	☐ NO
Sore throat or voice change	☐ YES	☐ NO
Throat swelling	☐ YES	☐ NO
Difficulty swallowing	☐ YES	☐ NO

Heart and cardiovascular

Chest pains	☐ YES	☐ NO
Sudden heartbeat changes/palpitation	☐ YES	☐ NO
Swelling of feet, ankles, hands	☐ YES	☐ NO
Heart disease, high blood pressure, or arrhythmia	☐ YES	☐ NO
Fainting spells	☐ YES	☐ NO
High cholesterol	☐ YES	☐ NO

Respiratory

Coughing	☐ YES	☐ NO
Asthma or wheezing	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Excessive phlegm (sputum) If yes, ☐ Clear ☐ Discolored	☐ YES	☐ NO
Chest tightness	☐ YES	☐ NO
Chest congestion	☐ YES	☐ NO

The Asthma Center

Review of Systems

Spitting up blood	☐ YES	☐ NO
History of:		
Bronchitis	☐ YES	☐ NO
Pneumonia	☐ YES	☐ NO
Pleuritis	☐ YES	☐ NO
Croup/bronchiolitis	☐ YES	☐ NO
Sarcoidosis	☐ YES	☐ NO
Pulmonary embolus or deep-vein thrombosis	☐ YES	☐ NO
Tuberculosis or positive tuberculin test	☐ YES	☐ NO
Shortness of breath on exertion	☐ YES	☐ NO
COPD	☐ YES	☐ NO
Does cold air trigger your symptoms?	☐ YES	☐ NO
Do you wheeze with colds?	☐ YES	☐ NO
Do allergies trigger your symptoms?	☐ YES	☐ NO
Have you ever been on a ventilator?	☐ YES	☐ NO

Gastrointestinal

Chronic abdominal pain	☐ YES	☐ NO
Blood in stool	☐ YES	☐ NO
Change in bowel movements	☐ YES	☐ NO
Persistent nausea or vomiting	☐ YES	☐ NO
Frequent diarrhea	☐ YES	☐ NO
Painful bowel movements or constipation	☐ YES	☐ NO
Loss of appetite	☐ YES	☐ NO
Liver disease/disorder	☐ YES	☐ NO
Jaundice	☐ YES	☐ NO

Genitourinary

Kidney stones	☐ YES	☐ NO
Kidney disease/disorder	☐ YES	☐ NO
Burning or painful urination	☐ YES	☐ NO
Blood in urine	☐ YES	☐ NO
Frequent urination	☐ YES	☐ NO
Women only:		
Painful urination	☐ YES	☐ NO
Blood in urine	☐ YES	☐ NO
Increased frequency of urination	☐ YES	☐ NO
Have your periods stopped?	☐ YES	☐ NO
Excessive flow/pain	☐ YES	☐ NO
Hysterectomy	☐ YES	☐ NO
Date of your last menstrual period: ___________________		

Review of Systems

Men only:		
Painful urination	☐ YES	☐ NO
Blood in urine	☐ YES	☐ NO
Increased frequency of urination	☐ YES	☐ NO
Urinating more than twice a night	☐ YES	☐ NO
Loss of control of your urine	☐ YES	☐ NO

Endocrine

Thyroid disease	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Low blood sugar	☐ YES	☐ NO
Excessive thirst or urination	☐ YES	☐ NO
Heat or cold intolerance	☐ YES	☐ NO
Glandular or hormone problem	☐ YES	☐ NO
Rash or itching	☐ YES	☐ NO
Change in skin color	☐ YES	☐ NO
Excessive appetite	☐ YES	☐ NO

Hematologic/Lymphatic

Easily bruise or bleed	☐ YES	☐ NO
Swollen glands in neck, armpits and groin	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Phlebitis	☐ YES	☐ NO
Transfusion	☐ YES	☐ NO
Slow to heal after cuts	☐ YES	☐ NO
Lyme disease	☐ YES	☐ NO
HIV/AIDS exposure	☐ YES	☐ NO

Musculoskeletal

Joint stiffness or swelling	☐ YES	☐ NO
Weakness of muscles/joints	☐ YES	☐ NO
Muscle pain or cramps	☐ YES	☐ NO
Muscle stiffness	☐ YES	☐ NO
Back pain	☐ YES	☐ NO
Joint pain	☐ YES	☐ NO
Difficulty walking	☐ YES	☐ NO
Cold extremities	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO

Neurological

Light-headed or dizzy/vertigo	☐ YES	☐ NO
Convulsions or seizures	☐ YES	☐ NO

The Asthma Center

Review of Systems

Numbness or tingling sensations	☐ YES	☐ NO
Tremors/hands shaking	☐ YES	☐ NO
Frequent or recurrent headaches	☐ YES	☐ NO
Migraine headaches	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Head injury	☐ YES	☐ NO
Paralysis	☐ YES	☐ NO
Fainting spells	☐ YES	☐ NO
Attention deficit disorder	☐ YES	☐ NO

Psychiatric

Nervousness	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Sleep problems	☐ YES	☐ NO
Memory loss or confusion	☐ YES	☐ NO
Difficulty concentrating	☐ YES	☐ NO
Phobias/unexplained fears	☐ YES	☐ NO
Bipolar disorder	☐ YES	☐ NO

Skin

Change in hair or nails	☐ YES	☐ NO
Skin rashes	☐ YES	☐ NO
Itchy skin	☐ YES	☐ NO
Chronic dry skin	☐ YES	☐ NO
Suspicious moles or other skin abnormalities	☐ YES	☐ NO
Eczema	☐ YES	☐ NO
Urticaria/angioedema	☐ YES	☐ NO
Fungal infection	☐ YES	☐ NO
Contact dermatitis	☐ YES	☐ NO
Acne	☐ YES	☐ NO
Rosacea	☐ YES	☐ NO
Seborrheic dermatitis	☐ YES	☐ NO
Psoriasis	☐ YES	☐ NO

CO-PAYMENT POLICY

It is our policy, and the policy of your insurance company, that all co-payments be paid at the time of medical service.

We have given our receptionists instructions to collect all co-payments due at each visit. There are no exceptions to this policy.

The rising cost of repeatedly billing some patients for co-payments has now become an unnecessary and expensive burden for our practice. Therefore, there will be at $10 billing charge for each co-payment not paid at time of service.

Patients that repeatedly fail to adhere to this policy will not be seen by the physician on days that they do not pay their co-payment.

REFERRAL POLICY

Guidelines for patients whose healthcare insurance requires a referral, issued by their Primary Care Physician, in order to be treated by The Asthma Center specialist.

Your healthcare insurance requires that you have a valid referral for each and every office visit and procedure, which in turn, gives our group authorization to provide these services. Your Primary Care Physician is the only one who may issue a referral.

It is advisable to obtain your referral well in advance of your office visit with The Asthma Center specialist.

ATTEMPTING TO GET A PROPER REFERRAL ON THE DAY OF YOUR VISIT IS USUALLY UNSUCCESSFUL.

It is the patient's responsibility to review his/her referral prior to the office visit to verify that the referral has been properly completed, is valid and lists all the proper procedures (i.e. spirometry, skin testing, allergy injection, etc.). If your primary care physician faxes a referral to us, it would be wise to obtain and review a photocopy of their fax prior to your visit. If electronic referrals are used, please review with your primary care physician's office staff specifically what services have been requested. **IF YOUR REFERRAL IS ISSUED ELECTRONICALLY OR SENT BY FAX, YOU MUST CONTACT OUR OFFICE AND LET US KNOW SO THAT WE HAVE PROPER AUTHORIZATION FOR YOUR VISIT.**

Patients arriving at our office without the proper referral will be offered the following options:

a) Reschedule the office visit.

b) Accept financial responsibility for the office visit and/or specific procedure not listed by signing our "financial responsibility form." Then the patient may be seen by the doctor.

c) You may use our telephone to call your primary physician in order to request an immediate referral by fax (urgent cases only). This usually is time consuming and unsuccessful since your primary care physician may not be available at the time of your visit or may require advance notice for referrals.

In order to avoid referral problems, it is wise to understand the referral process:

a) Know what must be specified on your referral by checking The Asthma Center request sheet given to you at the end of each visit and reviewing with The Asthma Center specialist what is planned for your next visit.

b) Personally verify that all of your necessary procedures are actually specified on the referral.

c) Check the referral date to be sure it has not expired prior to your next office visit.

d) Obtain the referral at least one week prior to your visit.

e) Keep a copy of your referral with multiple visits until the last one has been used.

We have tried to make the referral process as "user-friendly" as possible. Please do not be upset or angry with our office if you meet frustration with your healthcare insurance referral policy. We are simply following the procedures with your medical insurance has set for your healthcare and for which you have contracted.

Please sign below indicating that you have read and understand the above policy statements.

__________________________ __________________________________

Date (Patient's or Legal Guardian's Signature)

Allergic Disease Associates, P.C.
Specializing in Allergy, Asthma, Clinical Immunology & Non Surgical Sinus Disorders

Allergy Skin Testing Instructions

PLEASE DO NOT TAKE ANTIHISTAMINES FOR AT LEAST 3 DAYS PRIOR TO ALLERGY SKIN TESTING.

If you are scheduled for skin testing to antibiotics, local anesthetics, insect venoms, and/or other biological agents, the same guidelines apply. **No prescription or over-the-counter antihistamines should be used 3 days prior to the scheduled skin testing appointment.** These include cold tablets, sinus tablets, hayfever medications or oral medications for itchy skin. Some names of commonly used antihistamines include Actifed, Allegra, Atarax, Benadryl, Tavist, chlorpheniramine, Chlortrimeton, Teldrin, Co-Tylenol, Bromfed, Claritin, Dimetapp, Dristan, Drixoral, hydroxyzine, Ornade, and Zyrtec. If you have any questions regarding whether or not you are using an antihistamine, please contact our office.

Certain other medications may interfere with skin testing because they have antihistamine-like properties. One example is tricyclic anti-depressants (Adapin, Amitriptyline, doxepin, Elavil, Sermatril, Sinequan, Tofranil). If you are taking one of these medications, please notify us so that we can determine whether skin testing can be done. These medicines should not be stopped unless you have discussed their use with us. Long-term topical steroids (creams and ointments) may also have an effect on the local skin test site.

You may take the following medications: 1) You may continue your intranasal allergy sprays such as Atrovent, Beconase, Flonase, Nasacort, Nasarel, Nasonex, Rhinocort, and Vancenase. Astelin should be withheld for 5 days prior to testing. 2) All asthma inhalers, theophylline medications and leukotriene modifiers (Accolate, Singulair, Zyflo) do not interfere with skin testing and should be continued as prescribed. 3) Most medications do not interfere with skin testing, but make certain the nurse is aware of every drug that you are taking prior to skin testing. Please let the physician and/or nurse know, prior to skin testing, if you are taking any beta-blockers or anti-depressants, if you are pregnant, if you have a fever or if you are wheezing.

After skin testing, your results will be reviewed with one of The Asthma Center physicians who will make recommendations regarding your treatment.

We request that you do not bring small children with you when you are scheduled for skin testing, unless they are accompanied by another adult who can sit with them in the reception room.

Please do not cancel your appointment for skin testing since the time set aside for your skin testing is exclusively yours and special antigens have been prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours notice due to the length of time scheduled for skin testing. A last minute change results in the loss of valuable time that another patient might have utilized.

010223

HIPAA Acknowledgment and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Allergic Disease Associates, PC / The Asthma Center of its Notice Regarding Privacy of Personal Health Information containing a more complete description of the uses and disclosures of my health information (available in any of its offices in print form or on the website www.asthmacenter.com). I have been given the right to review such Notice Regarding Privacy of Personal Health Information prior to signing this consent. I understand that Allergic Disease Associates, PC / The Asthma Center has the right to change its Notice Regarding Privacy of Personal Health Information from time to time and that I may contact Allergic Disease Associates, PC / The Asthma Center or access its website at any time to obtain a current copy of the Notice Regarding Privacy of Personal Health Information.

I understand that I may request in writing that Allergic Disease Associates, PC / The Asthma Center restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Allergic Disease Associates, PC / The Asthma Center is not required to agree to my requested restrictions, but if Allergic Disease Associates, PC / The Asthma Center does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Allergic Disease Associates, PC / The Asthma Center has taken action relying on this consent.

____

Patient’s or Legal Guardian’s Name (Please Print) Date of Birth

____

Signature Date

110909