DATE:_____

The Asthma Center
ALLERGIC DISEASE ASSOCIATES, P.C.

Sec. Initials:

PATIENT NAME: (Last)_____ (First)_____

Cell: _____ Home:_____ Work: _____

Email:_____

ADDRESS: (Street)_____

(City)_____(State)_____(Zip)_____

Date of Birth:_____ Sex: ☐ Male ☐ Female Race\Ethnicity:_____

Emergency Contact Name:_____ Phone No.:_____

Family Physician: ☐ MD ☐ DO _____ Phone No.:_____ Fax:_____

Address:_____ (City)_____ (State)_____ (Zip)_____

Referring Physician: ☐ MD ☐ DO _____ Phone No.:_____ Fax:_____

Address:_____ (City)_____ (State)_____ (Zip)_____

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

Pharmacy Name:_____ Pharmacy Phone No.:_____

PRIMARY INSURANCE

Insurance Name_____

Guarantor*_____

List person or insured name responsible to ensure payment of all covered & non-covered services.

Guarantor DOB_____

ID # _____

Group # _____

Relationship to patient_____

Employer Name _____

Employer Phone # _____

SECONDARY INSURANCE

Insurance Name_____

Guarantor*_____

List person or insured name responsible to ensure payment of all covered & non-covered services.

Guarantor DOB_____

ID # _____

Group # _____

Relationship to patient_____

Employer Name _____

Employer Phone # _____

Medicare and 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, PC** for services rendered. It is the policy of Allergic Disease Associates PC and the policy of my insurance company that all co-payments be collected at the time of the medical service. There may be a $10 billing charge for each co-payment not paid at the time of service. I have received a copy of the Allergic Disease Associates, P.C. Practice Policies.

Signature: _____

HIPAA Notice of Privacy Practices:
Acknowledgment and Consent Form

The Asthma Center
ALLERGIC DISEASE ASSOCIATES, P.C.

Patient Name:_____**DOB:**_____

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 my treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluations, and physician certifications.

I give permission for Allergic Disease Associates, PC / The Asthma Center to:

☐ Leave a message regarding appointments and test results at _____ (phone number).

☐ Share my protected health information with a physician:

Physician: _____ Phone: _____

Address: _____

☐ Share my protected health information with:

1) Name: _____ Phone: _____ Relationship: _____

2) Name: _____ Phone: _____ Relationship: _____

I have been informed by Allergic Disease Associates, PC / The Asthma Center of its Notice of Privacy Practices, containing a complete description of the uses and disclosures of my protected health information (available in all offices as well as on www.asthmacenter.com). I have been given the right and opportunity to review such Notice of Privacy Practices prior to signing this consent. I understand that Allergic Disease Associates, PC / The Asthma Center has the right to change its Notice of Privacy Practices 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 of Privacy Practices.

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 healthcare 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.

I acknowledge that it is my responsibility to inform the practice of any changes in the above information.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Patient Signature Date Witness Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining the acknowledgment

☐ Other (Please Specify) _____

Employee Initials_____ Date_____

New Patient Allergy History & Review of Systems

Patient Name: _____

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

☐ Allergies	☐ Coughing	☐ Medication Allergy
☐ Sinus Issues	☐ Nasal Congestion	☐ Food Allergy
☐ Asthma	☐ Post Nasal Drip (PND)	☐ Eczema/Rash
☐ Shortness of Breath	☐ Sneezing	☐ Hives
☐ Wheezing	☐ Runny Nose	☐ Other _____

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

Have you ever tried any medications for your symptoms? ☐ Yes ☐ No If yes, which?_____

Medical History

Have you ever had a:

☐ Flu Shot	Mo/Yr:_____	☐ Zostavax (Shingles)	Mo/Yr:_____
☐ Tdap (Tetanus, Diptheria, Acellular Pertussis)	Mo/Yr:_____	☐ + PPD	Mo/Yr:_____
☐ Pneumonia Shot	Mo/Yr:_____		

Have you been seen by:

Allergist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Cardiologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Dermatologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Endocrinologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
ENT	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Gastroenterologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Rheumatologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____
Neurologist	☐ Yes	☐ No	Mo/Yr:_____	Name:_____

We would like any recent chest and sinus x-rays/CT scans and laboratory studies. Please bring a copy of the report with you or have it faxed to our office prior to your appointment.

Medication List:

Drug Name	*Milligrams (mg)*	*Frequency*

List any diagnosed medical conditions and surgical procedures:

Allergy Skin Testing:
Instructions, Information, and Informed Consent

The Asthma Center
ALLERGIC DISEASE ASSOCIATES, P.C.

Patient Name:_____ **DOB:**_____

DO NOT TAKE PRESCRIPTION OR OVER THE COUNTER ANTIHISTAMINES FOR 3 DAYS PRIOR TO YOUR SCHEDULED SKIN TESTING APPOINTMENT. If you have any questions regarding whether or not you are using an antihistamine, please contact our office.
You may continue all lung inhaler medications.

We request you do not bring small children with you when you are scheduled for skin testing, unless accompanied by another adult. At the beginning of your appointment, please inform the physician and/or nurse, prior to skin testing, if you are taking any beta-blockers or tricyclic anti-depressants, if you are pregnant, if you have a fever or if you are having difficulty breathing.

Allergy skin tests are methods of testing for allergy antibodies by introducing small amounts of the suspected allergens into the skin and noting whether positive reactions occur. Positive reactions consist of hive-like swellings and/or redness in the area surrounding the injection site. The results are read 10-20 minutes after the application of the allergens.

Several skin test methods are employed by our practice:

1) Prick method: In this method, the skin is pricked with a needle where drops of allergen had been previously placed. This is typically done on the back or, sometimes, on the forearm.
2) Intradermal method: This method consists of injecting small amounts of allergens into the superficial layers of the skin. This is typically performed on the upper arms and is done if the prick testing for the aero-allergen is negative.
3) Multi-test method: Allergen solutions are placed on the individual prongs of a multi-pronged plastic device that is pressed firmly on the back for < 5 seconds and then removed. This is typically done on the back and is reserved for young children.

Please notify the physician or clinical staff if you have a history of fainting during blood draws, receiving injections or any other procedure.

Interpretation of the clinical significance of skin test results requires careful review of the test results as well as a thorough review of the patient's history. Correlation of the skin test results and the patient's clinical history is essential in establishing which allergies are of clinical significance. After skin testing, your results will be reviewed by one of The Asthma Center physicians who will make recommendations regarding your treatment.

When you or your child come to our office for skin testing, you may be tested for allergic sensitivity to important selected aeroallergens and foods. In the metropolitan Philadelphia, Central and South Jersey areas, these may include trees, grasses, weeds, molds, dust mites, animal danders, and food allergens. The skin testing session usually takes 40 minutes. We recommend our patients wear a short-sleeve shirt on the day of the appointment in case intradermal testing is performed. Prick testing for adults and older children will be performed on the back followed by intradermal testing on the arms. The tests will be read within 10-20 minutes of application. Positive skin tests will gradually disappear over 30 minutes and, typically, no treatment is necessary.
Occasionally, local swelling at test sites will begin 4-8 hours after the skin tests were applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next several days. The use of topical steroids for these reactions may be helpful. Sometimes large local reactions will occur and last longer than a few days. Call The Asthma Center physicians if you have any questions regarding you or your child's reactions to skin testing.

Rarely, reactions may occur with skin testing that require immediate medical attention. These reactions may consist of any or all of the following symptoms:

- Itchy eyes, nose or throat
- Nasal Congestion or runny nose
- Tightness in the throat or chest
- Wheezing
- Shortness of breath
- Nausea or vomiting
- Hives and generalized itching
- Feeling faint or light-headedness
- Shock – only under extreme circumstances

Please note that these reactions rarely occur, and if any such reaction would occur, our staff is fully trained and available to treat these reactions.

Informed Consent

I have read the patient information sheet on allergy skin testing and understand that the opportunity has been provided to me to ask questions regarding the potential side effects of allergy skin testing. These questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me or my child against such reactions. All of my questions have been answered.

_____ _____ _____ _____
Patient's Signature Date Witness Signature Date

Note: For all patients who have received this information sheet and informed consent prior to your skin testing, please bring this form with you to your appointment. You may sign it before or during your visit.

RCAT (Rhinitis Control Assessment Test)

For Ages 12 and Up

Patients:
If you have any nasal symptoms, please complete the assessment test.

A. ***Write the number of each answer in the score box provided.***
B. ***Add up the score boxes and write in the total.***

1. <u>During the past week</u>, how often did you have nasal congestion? **SCORE**

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

2. <u>During the past week</u>, how often did you sneeze?

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

3. <u>During the past week</u>, how often did you have watery eyes?

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

4. <u>During the past week</u>, to what extent did your nasal or other allergy symptoms interfere with your sleep?

Not at all	A little	Somewhat	A lot	All the time
5	4	3	2	1

5. <u>During the past week</u>, how often did you avoid any activities (for example, visiting a house with a dog or cat, gardening) because of your nasal or other allergy symptoms?

Never	Rarely	Sometimes	Often	Extremely Often
5	4	3	2	1

6. <u>During the past week</u>, how well were your nasal or other allergy symptoms controlled?

Completely	Very	Somewhat	A little	Not at all
5	4	3	2	1

TOTAL

New Patient Referral Intake Survey

1. How Did You Hear About Us? (Check all that apply)

- ☐ Facebook
- ☐ Family
- ☐ Friend
- ☐ Insurance Company
- ☐ Newspaper
- ☐ Online Search
- ☐ Physician
- ☐ Pollen Counts
- ☐ Radio
- ☐ Review Website (Yelp, Healthgrades, etc)
- ☐ Television
- ☐ Other (please specify)_____

2. What Made You Choose Us? (Check all that apply)

- ☐ Advertising
- ☐ Available Appointment
- ☐ Insurance Accepted
- ☐ Location
- ☐ Online Reviews
- ☐ Personal Recommendation
- ☐ Physician's Credentials
- ☐ Size of Group
- ☐ Other (please specify)_____

3. What is your age? (New Pt or Parent/Guardian of New Pt)

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

4. What is your gender?

- ☐ Female
- ☐ Male

5. Zip Code_____