Welcome to The Asthma Center! We have put together a few tips and guidelines to make your first appointment as effective as possible. We are looking forward to seeing you in the office for the first time!

### Before Your Visit Checklist

- **Fill out** the enclosed New Patient Forms.
- **Do not** take prescription or over-the-counter antihistamines for the 3 days prior to your first visit as antihistamines can interfere with allergy skin testing.
- **Take** asthma medications as usual.
- **Ask** questions about medications that may interfere with your testing by calling the office where you are scheduled.
- **Prepare** information about:
  - Previous diagnosis, treatments, surgeries and testing (if any)
  - List of current medications
  - Copy of recent lab work and/or x-rays
  - A proper referral if required by your insurance
  - Insurance card and photo ID, which are required for your visit

### Day Of Your Visit Checklist

- **Bring** all information prepared above, information about: (1) previous diagnosis, treatments, surgeries and testing (2) list of current medications (3) copy of recent lab work and/or x-rays (4) proper referral if required by your insurance, and (5) insurance card and photo ID
- **Wear** short-sleeve shirt in case allergy skin testing is performed on the upper arm.

### What To Expect During Your Visit

First visits often takes 2 – 3 hours, depending on how complicated the medical conditions are and what testing might be needed. You will be seen by one of our nurses and one of our board-certified allergists. The physician will review all your current symptoms, past medical history, environmental exposures, and will conduct a physical examination. Skin testing and/or a brief breathing test may be concurrently done during this time. We recommend our patients wear a short-sleeve shirt on the day of the appointment in case intradermal allergy skin testing is performed on the upper arm.

Kindly provide at least 24 hour notice if you must cancel your visit with us.
FILL IN THIS FORM

DATE: ____________________

ALLERGIC DISEASE ASSOCIATES, P.C.

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

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
- [ ] Sinus Issues
- [ ] Asthma
- [ ] Shortness of Breath
- [ ] Wheezing
- [ ] Coughing
- [ ] Nasal Congestion
- [ ] Post Nasal Drip (PND)
- [ ] Sneezing
- [ ] Runny Nose
- [ ] Medication Allergy
- [ ] Food Allergy
- [ ] Eczema/Rash
- [ ] Hives
- [ ] 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, Diphtheria, 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:

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Milligrams (mg)</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List any diagnosed medical conditions and surgical procedures:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Allergy Skin Testing: Instructions, Information, and Informed Consent

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 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

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.

<table>
<thead>
<tr>
<th>Patient’s Signature</th>
<th>Date</th>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

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. During the past week, how often did you have nasal congestion?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Extremely Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

SCORE

2. During the past week, how often did you sneeze?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Extremely Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

SCORE

3. During the past week, how often did you have watery eyes?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Extremely Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

SCORE

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

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>A lot</th>
<th>All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

SCORE

5. During the past week, 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?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Extremely Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

SCORE

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

<table>
<thead>
<tr>
<th>Control Level</th>
<th>Completely</th>
<th>Very</th>
<th>Somewhat</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL
New Patient Referral Intake Survey

1. Name: (First) ___________________________________ (Last) ___________________________________

2. 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) __________________________________________

3. 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) __________________________________________

4. 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

5. What is your gender?

- Female
- Male

6. Zip Code ____________________________________________

7. Email Address _______________________________________

By providing my email address I am signing up to receive emails from The Asthma Center. Emails include office announcements & emergency closures, allergy shot hours, pollen counts, allergy & asthma news and health tips, and other marketing communications. Subscriptions can be managed online and unsubscribed at any time. No medical information and no protected health information (PHI) will be exchanged through this service.