Allergy & Asthma Wellness
885 Park Avenue Suite 1A
New York City, New York 10075
www.AllergyAsthmaWellness.com

Date: _____

PATIENT INFORMATION

First Name: _____ Last Name_____

Date of Birth: _____ Sex: ☐Male ☐Female

Home Address: _____ Email:_____

Apt:_____ City: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Patient is : ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Student ☐Child

Preferred Contact Method: ☐Home Phone ☐Cell Phone ☐Email ☐Other_____

HOW DID YOU HEAR ABOUT ALLERGY & ASTHMA WELLNESS?_____

YOUR OTHER DOCTORS

Primary Care Physician: _____ Phone:_____

Referring Physician:_____ Phone:_____

ENT (Ear Nose Throat):_____ Phone:_____

INSURANCE SUBSCRIBER/GUARANTOR (if insurance is not in patient's name)

Primary Insurance_____ Phone:_____

Insurance Address_____

ID # _____ Group #_____

Name of Insured_____Employer_____Relationship_____

Insured's Social Security_____ Date of Birth_____

Referral Required? Circle Y N Copay $_____

Secondary Insurance_____ Phone: _____

Insurance Address_____

ID # _____ Group #_____

Name of Insured_____Employer_____Relationship_____

Insured's Social Security_____ Date of Birth_____

Referral Required? Circle Y N Copay $_____

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PREFERRED PHARMACY

Company/Pharmacy:_____

Address/Cross Streets:_____ Phone Number:_____

City:_____ Zip:_____

EMERGENCY CONTACT

Name:_____ Phone:_____

I hereby authorize Allergy & Asthma Wellness, to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named Physician of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney/collection agency for collection, that I will be responsible for collection fees, attorney's fees, and court cost and interest.

Signature _____ Date _____
Patient/Guardian Signature

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_____

Today's Date Patient's Name Patient's DOB

HEALTH HISTORY FORM

Your answers on this form will help your health care provider better understand your medical concerns and conditions.

Please take time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit:_____

REVIEW OF ORGAN SYSTEMS: Please check any current and past problems.

___ Abnormal sense of taste or smell
___ Arthritis
___ Blood/Bleeding Disorders
___ Breathing with mouth open at night
___ Cancer
___ Cough, Wheeze or Shortness of Breath
___ Diabetes
___ Dizziness
___ Fever
___ Gastrointestinal Disorder, Heartburn or Indigestion
___ Headaches
___ Heart Disease
___ High Blood Pressure
___ Immunologic Disease
___ Infections Disease (HIV/TB)
___ Insect Allergy
___ Lung Disease
___ Neurological Disorder/Seizures
___ Psychological Disorder/Depression
___ Skin Disease
___ Snoring
___ Thyroid Disorder
___ Unexplained change in weight

WHAT MEDICATIONS ARE YOU TAKING? (over-the-counter products, vitamins, birth control, herbal remedies)

Medication Dose (e.g., mg/pill) How many times per day

_____
_____
_____
_____
_____

Have you been hospitalized? Please list approximate dates and reasons:

_____ _____

_____ _____

Have you had surgery? Please list approximate dates and reasons:

_____ _____

_____ _____

Do you have any medication allergies? Yes ____ No ___

If YES please list:_____

Do you have any food allergies? Are there any foods you suspect? Yes ___ No ___
If YES please list: _____

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FAMILY HISTORY (Please indicate family members with any of the following conditions):

	Mother	Father	Sibling
Allergies	☐	☐	☐
Hay fever	☐	☐	☐
Chronic stuffy/runny nose	☐	☐	☐
Sinus problems	☐	☐	☐
Asthma	☐	☐	☐
Allergies to food	☐	☐	☐
Immunologic disorder	☐	☐	☐
Respiratory diseases	☐	☐	☐
Skin disorders	☐	☐	☐
Heart Disease	☐	☐	☐
Cancer	☐	☐	☐
Thyroid disease	☐	☐	☐
Diabetes	☐	☐	☐
High blood pressure	☐	☐	☐
Other _____	☐	☐	☐

ENVIRONMENT:

Do you have pets at home? Yes ___ No ___

If YES, please circle: Cat Dog Bird Other_____

List Breed: _____

Do you smoke? Yes ___ No ___ Have you ever smoked? Yes ___ No ___ Quit Date: _____

How many packs per day? _____ # of years _____

Are there any smokers living in the home? Yes ___ No ___

What type of work do you do?_____

Are you exposed to anything at work that you are concerned may affect your health? _____

When was your last chest x-ray? (Please list date and where it was done) _____

IMMUNIZATIONS:

Are the patient's immunizations up to date: Yes ___ No ___

If NO, please explain:_____

Did you have the influenza vaccine this year? Yes ___ No ___

Who completed this form? _____

Name Relationship to Patient

Signature: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

I_____(the patient) acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature of Patient or Responsible Party: _____

YOUR RIGHTS AND YOUR HEALTH INFORMATION

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. FOR ALL EMERGENCIES, CONTACT 911.
2. Email is an inherently insecure form of communication. Do not email any sensitive information. In case of an emergency, do not send an email to our staff, CALL 911. Please be aware that some email may go unanswered because the addressee may be out of the office or busy seeing patients. If you do not get a reply within 3 hours, we recommend that you call us to follow up.
3. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Allergy & Asthma Wellness at 885 Park Avenue New York City, New York 10075
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Allergy & Asthma Wellness at 885 Park Avenue New York City, New York 10075.
6. You must provide us with a reason that supports your request for amendment.

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7. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact Allergy & Asthma Wellness at 885 Park Avenue New York City, New York 10075
8. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Allergy & Asthma Wellness at 885 Park Avenue New York City, New York 10075.
9. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
10. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

PATIENT/GUARANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including stepchildren, I hereby authorize treatment by Allergy & Asthma Wellness.
2. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due Allergy & Asthma Wellness agree to pay all cost of collections including collection agency fees. I understand there is a $25.00 returned check fee should a check be returned for any reason.
3. I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from Medicare, Blue Shield and/or any other agency involved in the payment of my treatment.
4. I also direct and assign payment from said third parties to Allergy & Asthma Wellness. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to Allergy & Asthma Wellness for any charges not covered by insurance. If payment from my insurance is not received within 120 days, my account will become due and payable by me. Any balance remaining on the account after insurance pays will be due payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not payable by my insurance carrier are due immediately.
5. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or body fluids. In the event of such direct exposure, State laws require a sample of my blood to be tested for the presence of infectious diseases. The results of these tests will be released to me and my family and to the healthcare workers who suffered exposure.
6. The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon me both for the present treatment and that which may be rendered to me and my family in the future by Allergy & Asthma Wellness.
7. I authorize a copy of my Allergy & Asthma Wellness medical record to be forwarded to my Primary Care Physician as well as any and all attending or consulting practitioners.

I hereby authorize direct payment to Dr. David Erstein (doctor and/or any service supplier) of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, including collection fees, court costs, attorney fees, and prejudgment interest at the highest amounts allowed under the law, whether or not paid by insurance, and for all services rendered on my behalf or my dependents'. I authorize the doctor and/or any service supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible Party: _____

REFERRAL RESPONSIBILITY

This is to advise you that it is your responsibility, as a patient, to obtain a referral from your primary Care Physician for services rendered. This referral must be dated prior to the time of service. It is also your responsibility to keep track and make a copy of your referrals to be sure that the visits or length of time of the referrals do not run out. If a referral is not obtained, you will be responsible for the payment to the doctor.

Signature of Patient or Responsible Party: _____ Date:_____

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