ALLERGY & ASTHMA CARE, PLLC

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WELCOME!
We look forward to providing your care. Before your first appointment, please read and familiarize yourself with Allergy & Asthma Care's office policies below.

PAPERWORK
Please complete the enclosed registration and questionnaire. Please take the time to fill out these forms completely and accurately. **All paperwork must be completed PRIOR to your scheduled appointment time**. Please be aware that if your paperwork is not completed when you arrive for your appointment, you may be rescheduled. Please also bring your insurance card and any required co-payment to your appointment, if applicable.

ALLERGY TESTING
If you are scheduled to have allergy testing completed at your appointment, **please review the medications list and STOP medications, as appropriate**. If you have any concerns about discontinuing any of your medications, please contact our office immediately.

APPOINTMENT
Your appointment is scheduled for _____ at _____.

CANCELLATION POLICY
Should you need to cancel your appointment, we require 24 hours notice. We understand that emergencies do occur, but habitual same day cancellations will have a $50.00 charge assessed to your account. Please honor your appointments as best you can to avoid being charged this fee.

We look forward to meeting with you soon!

Thank you,

Allergy and Asthma Care Staff

Medications Patients Must Stop Using Before Initial Visit or Skin Testing

48 HOURS

- Tagamet (cimetidine)
- Zantac (ranitidine)
- Pepcid (famotidine)
- Axid (nizatidine)
- Benedryl (diphenhydramine)
- Tylenol PM
- Phenergan (promethazine)
- Motion sickness medications
- Topical steroid creams on testing sites (back and arms)

ONE WEEK

- Any over the counter antihistamine medications
- Allegra (fexofenadine)
- Zyrtec (cetirizine)
- Xyzal (levocetirizine)
- Claritin (loratadine)
- Clarinex (desloratadine)
- Alavert (loratadine)
- Atarax (hydroxyzine)
- Astelin / Astepro (azelastine) – nasal spray
- Patanase (olopatadine) – nasal spray
- Zatidor / Alaway (ketotifen) – eye drops
- Patanol / Pataday (olopatadine) – eye drops
- Optivar (azelastine) – eye drops
- Livostin (levocabastine) – eye drops
- Elestat (epinastine) – eye drops

TWO WEEKS

All of these are a specific class of antidepressant, any other antidepressants may be continued without effect on allergy testing.

THESE MEDICATIONS SHOULD NOT BE STOPPED UNLESS YOU CONSULT WITH YOUR PRIMARY CARE PHYSICIAN.

- Tofranil (imipramine)
- Anafranil (clomipramine)
- Aventyl, Pamelor (nortriptyline)
- Elavil, Endep (amitriptyline)
- Norpramin (desipramine)
- Surmontil (trimipramine)
- Vivactil (protriptyline)
- Luvox (fluvoxamine)
- Remeron (mirtazapine)

If you are reluctant to discontinue your medication we can still see you, but you may need to return for testing.

Allergy and Asthma Care, PLLC
Patient Registration Form

Patient Name_____ Date_____
First Middle Initial Last

Mailing Address _____City_____ State_____ Zip_____

Phone_____ **Primary Physician AND Phone** _____(_____)_____
Area Code/Home number

Social Security #_____ Birthday_____ Age _____ Sex_____
Month/Day/Year M/F

Marital Status_____ Spouse's Name and Birthdate_____
Single/Married

Place of Employment _____Work Phone # _____
Area Code/Work #/Extension

Occupation _____ Status_____ Can we contact you at work? _____
Full-time/Part time Yes/No

Primary Insurance_____ Policy Holder _____
Name of Insurance Company

Address to submit charges _____
Street/City/State/Zip *usually found on the back of your insurance card

Identification/Policy # _____ Group Number_____

Secondary Insurance_____ Policy Holder _____
Name of Insurance Company

Address to submit charges _____
Street/City/State/Zip *usually found on the back of your insurance card

Identification/Policy # _____ Group Number_____

Is patient age 18+ _____ Patient will receive statement unless AAC staff is notified of another person's responsibility
Y/N for payment on account if the answer is "Y".

If "N"
Mother/Guardian Name _____ Birthday_____ Age_____

Social Security # _____ Place of Employment _____

Occupation_____ Work # _____ Status _____
Full-time/Part-time

Address and Phone # if different than Patient _____

Father/Guardian Name _____ Birthday_____ Age_____

Social Security # _____ Place of Employment _____

Occupation_____ Work # _____ Status _____
Full-time/Part-time

Address and Phone # if different than Patient _____

Allergy and Asthma Care, PLLC

Financial Policy

We require full payment of *expected patient responsibility* at the time of service based on your insurance coverage. If you do not have health insurance, we expect payment on the day of service. We do offer adjusted rates for "Time of Service" payments that are available to all patients, regardless of insurance coverage. This reduces our billing costs and further allows us to keep our charges as low as possible.

Unless you choose to participate in the "Time of Service" plan, we will submit charges to your insurance carrier when complete information has been received. If insurance payment is delayed over 60 days, you will be expected to pay the balance. We will make all efforts to resolve issues for non-payment from your carrier. Any payments received from your insurance carrier after you have paid on your balance will be refunded to you within 14 days of receipt of overpayment.

If applicable, we will bill secondary insurance. Carrying primary and secondary policies does not alleviate all patient responsibilities: deductibles, co-pays, and patient responsibilities still apply. After receipt of insurance payments, the amount that is remaining is due in full within 14 days. We recommend reviewing all explanation of benefits received from all insurance companies.

If arrangements for payment are needed, a payment plan agreement will be completed and signed with our office staff. A confidential meeting will allow for questions and explanations of our policies. You will receive copies of all conditions agreed upon.

An insurance card must be presented at each office visit. Failure to present a card at the time of service will cause full payment to be due on that date.

Required referrals are the patient responsibility. Failure to obtain referral as indicated by your insurance coverage will result in the charge to be completely the patient responsibility and will be due at the time of service.

I have read and understand all policies listed above. I understand that I am responsible for payment in full for all charges from this office regardless of insurance coverage. I agree that insurance payments can be sent directly to Allergy and Asthma Care, PLLC.

_____	_____	_____
printed patient name	signature of responsible party	date

Allergy & Asthma Care, PLLC
Patient Questionnaire

Patient Name _____ Birth Date _____

Referring Physician _____ Date Questionnaire Completed _____

CURRENT MEDICAL HISTORY

1. **What are the primary medical complaints today:**

_____

In the past year these problems are _____ worse _____unchanged _____better

2. List current medications (include dose and frequency):

_____

_____

_____

3. Do you have any medication allergies? _____

If yes, list medication(s) and reaction: _____

PAST MEDICAL HISTORY

1. Significant childhood illnesses: _____

2. Other Medical Problems: (Diabetes, Heart Disease, Kidney Disease, High Blood Pressure, Arthritis, Cancer, etc.)

3. Surgeries? _____ If yes, specify and give year: _____

4. Hospitalizations? _____ If yes, specify and give year: _____

5. *As an infant* **did patient have: Colic _____ Eczema _____ Many formula changes _____**
Constant runny nose _____ Breathing problems _____ Any adverse reactions to immunizations _____

6. Has patient ever had any of the following tests? Indicate year and place done:

Chest X-Ray? _____ Sweat Test? _____ Breathing Tests? _____

Sinus X-Rays or CT scan? _____ Cardiac tests (EKG, echo, stress test) _____

PERSONAL HISTORY

1. **Is patient in school? _____ Grade? _____**
2. **Number of school or work days missed due to illness? _____**
3. **Has the patient ever smoked cigarettes? _____ Age patient began smoking cigarettes regularly? _____**

   How many packs a day did the patient smoke? _____Does patient currently smoke? _____

   How old was patient when they quit? _____
4. **Does patient drink alcohol regularly? _____ Does patient use any illegal drugs?_____**
5. **What has been the usual occupation or job for the patient? _____**
6. **Has the patient ever worked in any dusty or hazardous job? _____**

   Specify which job, total years of work, and amount of exposure. _____

   _____
7. **Has the patient ever been exposed to gas or chemical fumes at work?_____**
8. **Specify which job, total years of work, and amount of exposure. _____**

9. **List patient's hobbies? _____**

   _____

FAMILY HISTORY

1. **Mother: Age if living _____ Age at death _____ cause of death _____**

Father: Age if living _____ Age at death _____ cause of death _____

2. **Does patient have any children? _____ If yes, list ages and any medical problems _____**

3. **Does patient have any siblings? _____ If yes, list ages and any medical problems _____**

_____

4. **Please identify if parents (F/M), brother (B), sister (S), children (CH), grandparents (GF/GM) have any of the conditions listed below:**

Asthma_____	**Chronic Bronchitis _____**	**Hayfever_____**
Sinus Trouble_____	**Skin Allergy _____**	**COPD_____**
Hives (welts) _____	**Cystic Fibrosis _____**	**Emphysema _____**

Autoimmune Disease_____ **Repeated Infections** _____ **High Blood Pressure** _____

Heart Disease _____ **Arthritis** _____ **Other** _____

ALLERGY HISTORY

1. Check any of the following symptoms that patient had or now has.

Nose and Throat

_____ Frequent Colds

_____Chronic Congestion

_____ Chronic Nasal Discharge

_____ Chronic Sniffing

_____ Frequent Sneezing

_____ Frequent Rubbing/Itching

_____ Frequent Sore Throats

_____ Polyps

_____ Sinus Problems

_____ Headaches

_____ Post Nasal Drip

_____ Throat Clearing

_____ Snoring

Eyes

_____ Constant Circles

_____ Redness

_____ Itching/Rubbing

_____ Swelling

Chest

_____ Chronic Cough

_____ Shortness of Breath

_____ Wheezing

_____Tightness in Chest

_____ Exercise Intolerance

_____ Exercise Induced Wheezing

_____ Exercise Induced Cough

_____ Sputum or Phlegm

_____ Pneumonia

_____ Bronchitis

Ears

_____ Congestion

_____ Frequent Infections

_____ Fluid

_____ Ear Tubes

_____ Hearing Loss

_____ Speech Problems

Skin

_____ Eczema

_____ Hives (welts)

_____ Dryness

_____ Frequent Rashes

Miscellaneous

_____ Tires Easily

_____ Irritable

_____ Poor Weight Gain

_____ Weight Loss

_____ Fevers

_____ Chills

_____ Night Sweats

_____ Reaction to Insect Bites

_____ Reaction to Insect Stings

_____ Greasy, Fatty Stools

_____ Heartburn

_____ Mouth Breathing

_____ Hard to wake in morning

2. Has patient ever had allergy tests? _____ When? _____ Findings? _____

3. Has patient ever had allergy shots? _____ If yes, did they help? _____

4. Does patient have any problems eating certain foods? _____

If yes, specify foods and describe symptoms: _____

_____

_____

5. **Factors Affecting Allergies/Progress**

Please check the boxes that best describe patient's allergic response to each of the following:

	Better	Worse	No Change		Better	Worse	No Change
1. Dec.-Feb				**14. Dust**			
2. Mar-Apr				**15. Smoke**			
3. May-June				**16. Exercise**			
4. July-Nov.				**17. Odors**			
5. Morning				**18. Cold Weather**			
6. Afternoon				**19. Wind**			
7. Evening				**20. Infection**			
8. While Sleeping				**21. Weather Change**			
9. Inside House				**22. Cats**			
10. Outside House				**23. Dogs**			
11. Basement				**24. Other Animals**			
12. School/Work				**25. Grass/Mowing**			
13. Air Conditioning							

6. Check any of the following medicines or types of medicines you have used to treat your problem (s):

_____ Antihistamines (Allegra, Zyrtec, Claritin, Benadryl, etc.)

_____ Nasal Sprays (Afrin, Astelin, Nasonex, Flonase, Nasacort, Rhinocort, etc.)

_____ Breathing Treatments or Nebulizers

_____ Oral or Injectable Steroids (Prednisone, Cortisone, Kenalog, etc)

_____ Inhalers, specify _____

_____ Creams (triamcinolone, cortisone, Protopic, Elidel, etc.) _____

_____ Other Medications (Singulair, Xolair, theophylline, etc.) _____

ENVIRONMENTAL HISTORY

1. What type of dwelling does patient live in? House _____ Apartment _____ Trailer _____

2. How old is the dwelling? _____ How many years lived there? _____

3. Is there any free standing water nearby? _____

4. Check those things listed below that apply to your home:

_____ Dehumidifier _____ Central Air Conditioning/heat _____ Air Purifier

_____ Individual Wall Unit AC/heat _____ Pet (s), Specify _____ _____ Humidifier

_____ Visible mold or mildew **_____ Does anyone you live with smoke? (Even if they smoke outdoors)**

_____ Home on a dirt road **_____ Do you live on a ranch**

5. Check any of the following that are in the patient bedroom:

_____ Plastic mattress cover **_____ Plastic box spring cover** **_____ Stuffed toys** **_____ Curtains**

_____ Carpeting **_____ Feather Pillow** **_____ Pets Allowed** **_____ Books**

_____ Air Conditioning **_____ Air Vent**

Additional notes or concerns:

_____

_____

_____

_____

_____