

ALLERGY & ASTHMA CENTER

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2445 Marietta Avenue
Lancaster, Pennsylvania 17601

Telephone (717)-393-1365
By Appointment Only

APPOINTMENT DATE:

TIME:

APPOINTMENT OFFICE:

PHYSICIAN'S NAME:

Dear

PLEASE REVIEW THIS FORM AS SOON AS POSSIBLE

Welcome to our practice. We are dedicated to giving you the best quality care in the fields of allergy, asthma, and immunology. The following information will help you make the most of your time during your visit.

ABOUT YOUR VISIT

At your first consultation, your physician will review your allergy and/or asthma history and do an appropriate physical examination. You will be given the opportunity to discuss with your doctor your own concerns and questions related to allergy and asthma.

Your physician may order skin testing, which will be done during this first visit. Test findings will be discussed with you upon completion. There are often multiple tests; please allow a minimum of **three hours** for your first appointment. We also ask that you arrive **15 minutes early** to check in with our front desk staff. To avoid any delays with your appointment, please bring your **completed** paperwork, insurance card and any copy to your visit.

****Note:** A parent/legal guardian must accompany patients under 18 years old and plan to stay for the entire first appointment. For future appointments, an adult other than a parent/legal guardian may accompany a minor child with a signed Consent to Treat form.

MEDICAL INFORMATION

1. Two forms are enclosed **to complete before your initial visit**. Please be sure to bring them with you.

- **Medical History form:** Please complete as accurately as possible, including all questions in the personal allergy history section. **List all medications and supplements you take, including dosage and frequency of use.** Bring the medication supplements bottles with you.
- **Insurance Billing form:** Please complete the information necessary for our business office. **Bring your health insurance cards with you.**

Branch Offices

63-65 West Church Street Suite 75, Stevens, Pennsylvania 17578 (717) 336-0329

2. We need any relevant reports from **laboratory studies, CT scans, or x-rays** (blood work, CTs of sinuses, chest x-rays, etc. – not the films, just the reports.) done in the past six months, if any. **Please obtain copies of the reports**, and either bring them with you, or have them faxed to your appointment office at: (717)393-8540.

ABOUT SKIN TESTING

Should your doctor decide to do skin testing on the day of your appointment, **it is important that you stop taking certain medications EARLY** that interfere with the test results. Although other drugs may interfere, antihistamines are the **ONLY** medicines you should discontinue without prior authorization from your family physician. **DO NOT STOP ANY MEDICATION TAKEN FOR ASTHMA.** Drugs (antihistamines) to be stopped early are listed below. Call if you are uncertain.

Stop the following drugs SEVEN (7) days before your appointment:

Advil PM	Trinalin or Optimine
Alaway & Zaditor Drops	Veramyst
Astelin	All over-the-counter
Azelastine	antihistamines, cold
Astepro	medicines, and allergy eye
Deconamine	drops, such as: Benadryl,
Diphenhydramine	Dimetapp, Tavist
Dymista	products, Chlor-Trimeton,
Elestat Ophthalmic Solution	Actifed, Tylenol Allergy
Livostin Ophthalmic Solution	Sinus, Tylenol PM, Teldrin,
Optivar Ophthalmic Solution	PediaCare, Visine Allergy
Pataday	Relief, etc.
Patanol	OTC medications to help you
Patanase	sleep
Periactic (cyproheptadine)	
Rynatan	

Stop the following drugs SEVEN (7) days before your appointment:

Allegra/Fexofenadine	Promethazine
Products	Phenergan
AlleRx	Vistaril
Alavert	Xyzal/Levocetirizine
Atarax	Zyrtec/Cetirizine
Clarinet	Products
Claritin/Loratadine	
Products	Meclizine**
Doxepin	Antivert**
Hydroxyzine	

****If you are unable to STOP these medications please contact our office to discuss your appointment.
All other medications should be continued unless otherwise advised.**

FINANCIAL ARRANGEMENTS

1. Please bring your current medical **insurance card(s)** with you to the visit.
2. Be prepared to **pay your co-pay at the time of your visit**. We participate with most major insurance companies and will accept assignment.
3. If you are insured through an HMO plan, **it is your responsibility to obtain a referral** from your primary care physician before your visit. Either have your primary care physician fax it to us before your appointment or bring the completed form with you.
4. **It is the patient's responsibility to check with their insurance company as to the benefit coverage for allergy testing, allergy extract and the administration of allergy injections.**

YOUR APPOINTMENT – REMEMBER TO BRING:

- Completed Medical History form. Your doctor needs this information about you. To avoid any delays with your appointment, please bring your **completed** paperwork.
- Completed Insurance Billing form.
- Reports from any pertinent CT scans, chest x-rays, or laboratory studies done in the past six months
- Health insurance cards.
- Completed referral form from your primary care physician if you have HMO insurance.
- Co-pay.
- Your allergy and asthma questions for your doctor.

****Please Note:** In consideration for our patients who have allergic sensitivities to scented products, please do not wear perfume or cologne of any kind, scented hair sprays, etc. when visiting our office.

APPOINTMENT CANCELLATION POLICY

Many patients need our services. A last minute cancellation deprives someone else of an appointment time. Please notify our New Patient Coordinator of a cancellation or request for an appointment change at least 48 hours (two business days) in advance of your appointment. **If we do not have notification of your cancellation within 2 (two business days) of your appointment, either directly or by voice mail, there will be a \$75.00 fee for your absence.**

QUESTIONS?

If you have any questions about your initial visit or any part of the preceding instructions, please feel free to call.

For additional information about the practice, our physicians, and current allergy and asthma topics, please visit our website at www.allergydoctors.com.

Sincerely,

New Patient Coordinator

Emergency Weather Plan

AAC offices may need to open late or close early due to inclement weather.

In the event that conditions exist that make it hazardous for both our patients and employees we will notify the answering service and put a message on our phone system. AAC will also post any closures or delays at the top of the AAC website at www.allergydoctors.com.

Please Note

In consideration for our patients who have allergic sensitivities to scented products, please do not wear perfume or cologne of any kind, scented hair sprays, scented body spray, scented lotion, etc. when visiting our office.

Forms

Please complete all forms and send back to our office so that we receive them prior to your appointment date. You can either mail them back to us or you can fax them to 717-393-8540.

ALLERGY & ASTHMA CENTER

Please complete this form and give to Receptionist along with insurance card.

TODAY'S DATE _____

PATIENT INFORMATION

PATIENT'S NAME _____ M () F () SSN: _____ DOB: _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. (____) _____ MARITAL STATUS:(circle)S M D W LANGUAGE _____ RACE _____

EMAIL: _____ ETHNICITY: (circle) HISPANIC OR LATINO, NONHISPANIC OR LATINO, OTHER

EMPLOYER NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE NO. (____) _____ EXT _____ OCCUPATION _____

NEW PATIENT ____ YES ____ NO (IF NAME CHANGED; FORMER NAME) _____

REFERRING PHYSICIAN: NAME: _____, _____

ADDRESS _____ LAST _____ FIRST _____ PHONE NO. _____

FAMILY PHYSICIAN: NAME: _____, _____ MI: _____

ADDRESS _____ LAST _____ FIRST _____ CITY _____ ZIP _____

SPOUSE/PARENT/RESPONSIBLE PERSON'S INFORMATION

NAME _____ DOB: _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. (____) _____ SOCIAL SECURITY NO: _____

EMPLOYER'S NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. (____) _____ EXT _____ OCCUPATION _____

INSURANCE INFORMATION

INSURANCE COMPANY (Primary)
NAME _____
INS. COMPANY ADDRESS _____

ID # _____ GRP. PLAN _____

INSURED (if not patient) _____ Date of Birth _____

INSURER'S EMPLOYER
SOCIAL SECURITY # _____

INSURANCE COMPANY (Secondary)
NAME _____
INS. COMPANY ADDRESS _____

ID # _____ GRP. PLAN _____

INSURED (if not patient) _____ Date of Birth _____

INSURER'S EMPLOYER
SOCIAL SECURITY # _____

AUTHORIZATIONS

- 1) STATEMENT OF FINANCIAL RESPONSIBILITY: I hereby agree to pay Allergy & Asthma Center for all charges (to include co-pays, deductibles) at time of service; however, I understand that Allergy & Asthma Center may accept assignment of insurance benefits in lieu of payment at time of service. I further understand that Allergy & Asthma Center will attempt to collect the assigned insurance benefits; however, the full amount will still be my responsibility.
- 2) AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Allergy and Asthma Center to release any information including information regarding my diagnosis and treatment by the insurance company necessary to collect benefits under the policies stated at the time of treatment.

SIGNATURE _____
Patient or Legal Guardian Relationship to Patient Date

Patient Name: _____
AAC#: _____

Date: _____
Patient Signature: _____

REVIEW OF SYSTEMS

Do you have any of the following? (ANSWER YES OR NO)

Please provide explanations next to the various items if you experience them. (Examples: when, how often, and how severe?)

General

___ significant change in weight yes no
 up down
___ recent fevers or chills yes no

Endocrine

___ particularly intolerant to cold yes no
___ particularly intolerant to heat yes no

HEENT

___ Runny nose
___ Sneezing
___ Nasal itching
___ Eye itching
___ Nasal congestion
___ Post Nasal Drip

Gynecological

___ N/A
___ abnormal vaginal discharge recently
___ change in menstrual cycle
___ excessive bleeding

Skin

___ skin rashes (if you are here primarily for an evaluation of a rash we will discuss this in detail)
___ recurrent skin infections
___ Hives
How often:

Neurological

___ tingling or numbness in an extremity
___ unusual weakness-please describe

Psychological

___ excessive anxiety or worry
___ excessive sadness or depression

Respiratory

___ Wheeze
___ Shortness of breath
___ Cough
___ Coughs up blood

Gastrointestinal

___ acid taste or regurgitation of food
___ bloating
___ heartburn
___ nausea
___ vomiting
___ diarrhea
___ rectal bleeding
___ black bowel movements

Cardiovascular

___ ankle swelling
___ chest pain
___ palpitations

Urinary

___ blood in the urine
___ burning or pain with urination
___ loss of urine with coughing
___ trouble with urinary flow

Hematologic

___ anemia
___ bleeding
___ bruising easily

Musculoskeletal

___ joint pain

Patient Label

Name of Referring Doctor/Family Doctor: _____

MEMO TO NEW PATIENTS

AS A HELP TO OUR PROVIDERS, PLEASE WRITE A ONE TO THREE PARAGRAPH SUMMARY AS TO ONSET OF PROBLEM, MEDICATIONS USED, HOW HELPFUL EACH WAS, AND YOUR REMAINING SYMPTOMS.

ALLERGY & ASTHMA CENTER

New Patient Questionnaire

Patient's name: _____ Date: _____
 Sex: _____ Age: _____ Birthdate: _____
 Parent(s)' name(s) if patient is a minor: _____
 Street: _____ City: _____ State: _____ Zip: _____
 Home telephone: _____ Daytime telephone: _____ Cell Phone: _____
 Parent's or responsible party's name: _____

Name of physician who sent you here: _____
 Is there another doctor to whom a report should be sent? _____
 Names of other family members seen in the practice: _____

I. PERSONAL ALLERGY HISTORY

Patient's MAIN complaint: _____

When did the problem begin? _____

SYMPTOMS	Yes	No	?	SYMPTOMS	Yes	No	?
Trouble with your nose?				Trouble with your chest or breathing?			
Nasal Itching				Wheezing			
Frequent sneezing				Shortness of breath			
Clear watery discharge				Chest tightness			
White thick discharge				Cough			
Colored thick discharge				Symptoms noted with: Colds			
Drainage down back of throat				Exercise			
Periodic				Animals			
Constant				Other _____			
Nasal congestion				If cough, describe: Loose			
Periodic				Dry			
Constant				Constant			
Both sides				Periodic			
One side				Daytime			
Frequent throat-clearing				Nighttime			
Hoarseness/raspy voice				Colored mucus			
Frequent sore throats				Have you seen a physician or been seen in an Emergency room for wheezing?			
Frequent pressure headaches				Trouble with your skin?			
Loss of sense of smell				Rash			
Loss of sense of taste				Scaly patches			
Sinus infections				Hives			
Number per year _____				Swollen areas			
Nasal polyps				Poison ivy/oak			
Frequent nose bleeds				Contact rash			
Snoring				Trouble with your ears?			
Do you use nasal sprays?				Itching			
What type? _____				Popping			
Trouble with your eyes?				Fluid in ears			
Redness				Infection/pain			
Tearing/Watering				Decreased hearing			
Swelling							
Itching							
Burning							

What MEDICATIONS you have tried for your symptoms? Did they help? _____

Circle those things you think contribute to your symptoms or cause them to be WORSE:

- | | | | |
|------------------|--------------------|-------------------|-------------------|
| Indoors | Weather Change | Hay | Candles |
| Outdoors | Temperature Change | Barns | Paint Fumes |
| At Home | Wet Weather | Raking Leaves | Perfumes |
| At School | Dry Weather | Damp Areas | Smoke |
| At Work | Cold Day | Dusty Environment | Cleaning products |
| Morning | Hot Day | Air Conditioning | Newspapers |
| Afternoon | Hot/Humid Day | Animals | While eating |
| At Nights | Windy Day | Air Pollution | After eating |
| Viral Infections | Mowing Lawn | Chemicals | Emotions |

Certain drugs (describe): _____

Other: _____

II. MEDICAL HISTORY –

CIRCLE any conditions YOU HAVE (OR HAD IN THE PAST):

None

- | | | | |
|--------------|-------------|---------------------|--------------|
| Asthma | Migraine | Diabetes | Hepatitis |
| Hay Fever | Pneumonia | Kidney Disease | Tuberculosis |
| Eczema | Emphysema | Heart Disease | Arthritis |
| Bronchitis | Acid Reflux | High Blood Pressure | Cancer |
| Nasal Polyps | | | Other: _____ |

HOSPITALIZATIONS (list reason, date, and hospital) none

- 1) _____
- 2) _____
- 3) _____

LIST ALL MEDICATIONS you are now taking for ANY conditions. List dosages and how each is taken, or bring in your medications. *Example:* Advair 250/50, one puff twice a day: _____

Are you ALLERGIC to any MEDICATIONS? (Describe reaction): _____

Are you ALLERGIC to INSECT STINGS? (Describe reaction): _____

Are you ALLERGIC to any FOODS? (Describe reaction): _____

III. FAMILY HISTORY

FAMILY MEMBER	AGE	DISEASES	WHICH RELATIVE(S)?
Mother		Sinus Problems	
Father		Hay Fever	
Siblings (name)		Nasal Allergies	
		Asthma	
		Emphysema	
		Nasal polyps	
Spouse		Cystic fibrosis	
Children (name)		High Blood Pressure	
		Heart Disease	
		Diabetes	
		Arthritis	
		Cancer	

IV. OCCUPATIONAL HISTORY (If patient is your child, state your occupation—it may be influencing your child's condition)

What is your occupation? _____ Employer: _____

Do you feel your occupation has anything to do with your symptoms? Explain: _____

How long have you worked for your present employer? _____

IV. PERSONAL ENVIRONMENTAL HISTORY (Please check the correct answer or fill in the blank)

	YES	NO	?		YES	NO	?
HOME				BEDROOM			
Type of home: House				Bedroom has wall-to-wall carpeting			
Apartment				Pillow - Feather/Down filled			
Dormitory				Not Known			
Mobile home				Pillow covered in dust mite proof cover			
HEATING				Mattress covered in dust mite proof cover			
Home heating: Forced air				Central vacuum cleaner system			
Radiant air				PETS			
Air filters change every 3 mo.?				Do you have animals in your home?			
Kerosene Portable or Vented				Dog: # ()			
Gas				Cat: # ()			
Oil				Rabbit: # ()			
Coal				Rodent: # ()			
Wood				Ferret: # ()			
Vaporizer				Gerbil: # ()			
Cool mist Vaporizer				Hamster: # ()			
Steam Vaporizer				Guinea Pig: # ()			
Use: Constant use				Frog: # ()			
Occasionally used				Snake: # ()			
Used year-round				Bird # () Type of bird:			
Used when needed				Have you had pets longer than 3 months			
Do you use a portable air purifier?				Pets sleep in the bedroom			
Purifier HEPA filter-type				Patient/family member participates in the care of pets (type)			
Purifier ionizer-type							
# of Air-Purifiers: _____							
Are there damp inside walls?				SMOKING			
Where?				Have you ever smoked?			
				How long did you smoke?			
				How much did you smoke?			

Please circle the months of the year your symptoms are at their worst:

- | | | | |
|-----------|----------|----------|----------|
| January | February | March | April |
| May | June | July | August |
| September | October | November | December |

Are your symptoms year-round but worse during these months? Yes / No