Allergy Consultants, P.A. **Visit Date:**___________

Specialist in Pediatric and Adult Allergy, Asthma, and Sinus Disease

Arthur Fost, M.D. • David Fost, M.D. • Antonio de la Cruz, M.D. • Satya Narisety, M.D.

PATIENT INFORMATION

DATE ___________________________

Patient's Name____Date of Birth _____________________________

Last *First*

Address ____

City____________________________________ State__________________ Zip Code ______________________________

Cell Phone Number____________________________Home Phone Number ____

Email Address ____Social Security* _________________________________

Race: ❒ Caucasian ❒ Black or African American ❒ Asian ❒ Other ❒ Declined to report

Ethnicity: ❒ Hispanic or Latino ❒ Non Hispanic or Latino ❒ Declined to report

Languages spoken____

Marital Status S M W D SEP (Please circle one) **ADVANCED DIRECTIVE OR LIVING WILL ?** ❒ YES ❒ NO

Spouse's Name____Date of Birth ___________________________

Emergency Contact____ Relationship _____________________________

Home Phone__________________________________Work phone ____

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN

Name____Practice

Address____Phone Number

Pharmacy____Address

Pharmacy Phone________________________________Pharmacy Fax ____

RESPONSIBLE PARTY/POLICY HOLDER INFORMATION

Name_____________________________Relationship________________D. O. B.____________S. S. # ______

Address____Phone Number __

City_________________________________ State_________________Zip Code __________________________________

POLICY HOLDER EMPLOYMENT

Company Name ____

Address____Phone Number ______________________________

City____ State______________ Zip Code ____________________________

INSURANCE

Primary Company______________________________________ Secondary _____________________________________

ID Number____ ID Number ____________________________________

Group Number____ Group Number __________________________________

Subscriber____ Subscriber ____________________________________

Co-Pay $____________Effective Date______________________ Co-Pay $____________Effective Date _____________

Referral Required yes no (Please circle one) Referral Required yes no (Please circle one)

Allergy Consultants, P.A.

FINANCIAL POLICY / 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 Consultants, P.A.

2. I understand that payment of the required copay is due at the time of service. I direct and assign payment from any third party payer to Allergy Consultants. I understand that my insurance policy is a contract between me and the insurance company and that I am responsible to Allergy Consultants for any charges not covered by insurance. I also know that payment by the insurance company is not considered payment in full and that I am responsible for any amounts left un-paid by insurance, for any reason.

3. Should my insurance company require a specialist referral from my primary care physician before I can be seen by the physicians at Allergy Consultants, P.A., it is my responsibility to obtain that referral prior to my appointment as contracts with the insurance companies prohibit me from seeing the doctors without a referral. In the event that services are provided and my insurance is not in effect that day, or if my contract contains a pre-existing clause, I am responsible for payment as the patient - guarantor.

4. 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 payment of my treatment or that of my family.

5. I understand that I will be charged the finance charge of equal to 1% per month on any balance billed and left un-paid more than 30 days. I further understand that any amount left unpaid for more than 30 days will be considered delinquent, and may be referred to a collection agency or attorney as well as reported to the various credit reporting agencies. ... .

6. If my account is referred to a collection agency and/or attorney for collection, I agree to be responsible for the payment of an additional collection fee in an amount equal to 30% of my outstanding balance, inclusive of accrued interest. I also understand there is a $ 20.00 returned check fee should a check be returned for any reason.

Signature of Patient/Responsible Party

I hereby acknowledge that I have received AND reviewed a copy of Allergy Consultant, P.A.'s financial policy and Notice of Privacy Practice.

Signature:____

Relationship to Patient:____

Date:____

Printed Name of Patient:____

ALLERGY CONSULTANTS, P.A.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Allergy Consultants, PA to use and disclose protected health information (PHI) about me to carry out **treatment, payment and health care operations** (TPO). The Notice of Privacy Practices provided by Allergy Consultants, PA describes such uses and disclosures more completely). A copy of the Notice of Privacy Practices is available on our website, electronically by request and in all of our offices in an easy to read booklet form. By signing this form I attest that **I have received, read and understand the Notice of Privacy Practices**.

Allergy Consultants, PA reserves the right to revise its Notice of Privacy Practices at any time. I have the right to request that Allergy Consultants, PA restrict how it uses or discloses my PHI to carry out TPO.

With this consent, Allergy Consultants, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, amongst others. ___________yes ___________no

With this consent, Allergy Consultants, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
__________yes ___________no

With this consent, Allergy Consultants, PA may email to me any information or notices that assist the practice in carrying out TPO. __________yes __________no E-mail will only be sent in a HIPAA approved encrypted format.

The following person (s) may contact Allergy Consultants, PA inquiring in regards to my health information. You have my permission to release my health information to them.

Name:____Relationship:____________________________
Name:____Relationship:____________________________
Name:____Relationship:____________________________

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Allergy Consultants, PA may decline to provide treatment to me.

Signature of Patient or Legal Guardian:____

Print Patients name:____Date:__________________

Print name of Legal Guardian, if applicable:____

ALLERGY HISTORY FORM

Date of visit:____ ________________

____HEIGHT:______ _WEIGHT:_________

Name of Patient: ____ Age: __________

Referred By: ________________________ Primary Physician: ____________________

List other Physicians to receive a follow up letter:_______________________________________

____

____

What is the Major Reason(s) for Allergy Consultation:

____

____

____

____

Nasal and Eye Symptoms:

Check the following if they apply to you: ☐ **NONE**

☐ Nasal blockage ☐ Sneezing ☐ Post nasal drip ☐ Itchy nose

☐ Itchy eyes ☐ Headache ☐ Ear problems ☐ Other:

When are you symptomatic: ☐ Winter ☐ Spring ☐ Summer ☐ Fall

Medications taken and their effects:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Suspected or known causes of these symptoms:

☐ Colds ☐ Weeds ☐ Dust ☐ Latex

☐ Trees ☐ Cats ☐ Mold ☐ Foods:

☐ Grass ☐ Dogs ☐ Cigarette smoke ☐ Other:

Skin Problems:

☐ **NONE** ☐ ECZEMA ☐ HIVES ☐ RASH ☐ Other:

Approximate date symptoms first noted: ____

____

Known or suspected causes of the rash: ____

____

Complete the following section if there is a history of

Asthma, Wheezing, Bronchitis, or Chronic Cough:

Date symptoms first noted: ____________________________

Description of symptoms: ☐ Wheezing ☐ Cough ☐ Shortness of breath ☐ Chest tightness

☐ Tightness in throat ☐ Other:________________________

☐ Worse at night ☐ Worse during day ☐ Problem during day and night

Frequency of symptoms:
- ☐ Less than twice a week
- ☐ 3 or more days a week
- ☐ Every day
- ☐ More than 2 nights a week

Emergency Room visits:
- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ > 5

Hospitalizations:
- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ > 5

Medications taken for this and effects:

____ ____
____ ____
____ ____
____ ____

Suspected causes of attacks:

☐ Colds	☐ Pollen	☐ Cold air	☐ Other:
☐ Animals	☐ Emotions	☐ Foods (specify)	
☐ Exercise	☐ Cigarette smoke	☐ Latex	

Have you had any REACTIONS TO BEE/INSECT STINGS?

☐ None	☐ Local reaction at sting site	☐ Rash	☐ Breathing Problems
☐ Other:	☐ Never been stung		

Please check any additional problems you are experiencing:

☐ Depression	☐ Fatigue	☐ Visual Changes	☐ Hearing Problems
☐ Throat Problems	☐ Breathing Problems	☐ Chest Pain	☐ Palpitations
☐ Heartburn	☐ Bladder Problems	☐ Seizures	☐ Muscle Aches
☐ Joint Pains	☐ Rash	☐ Itching	☐ Bleeding Problems

Past Medical History:

List any **MEDICATIONS** taken in the past week (include aspirin and vitamins)

List all medical conditions: ☐ NONE

List all hospitalizations: ☐ NONE

List all emergency room visits: ☐ NONE

List all **REACTIONS** you have had to **FOODS**: ☐ NONE

Describe **PROBLEMS WITH MEDICATIONS**: ☐ NONE

Family History:

	AGE	ASTHMA	HAYFEVER	SKIN ALLERGY	OTHER
FATHER					
MOTHER					
BROTHERS					
SISTERS					
CHILDREN					

Environmental History:

List **ALL ANIMALS** in or around the home:

Note **ALL SMOKERS** who live in the home:

BEDROOM: Winter bedroom temperature: ___________________

Type of pillow: ☐ Synthetic ☐ Feather
Bedding: ☐ Feather Bed ☐ Feather comforter
Floor covering: ☐ Wall to wall carpet ☐ Area rug ☐ Wood floor ☐ Carpet over cement

Description of bedroom: ☐ Neat ☐ Cluttered ☐ Dusty ☐ Stuffed toys

HEATING SYSTEM: ☐ Forced hot air ☐ Electric baseboard ☐ Hot water baseboard
☐ Wood burning stove ☐ Other:

AIR CONDITIONING: ☐ None ☐ Window ☐ Central

BASEMENT:
☐ None ☐ Finished ☐ Unfinished ☐ History of water leakage

Please describe the **TYPE OF WORK** or **DAILY ACTIVITY**:
☐ Office setting ☐ Outdoors setting ☐ Homemaker ☐ School (grade:)

Please note any other history that you feel the doctor should know about you. If appropriate, note any stress or emotional problems that might affect your symptoms:

____
____
____
____
____