

**Allergy Consultants, P.A. Visit Date: \_\_\_\_\_**

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

Arthur Fost, M.D. • David Fost, M.D. • Satya Narisety, M.D. • Anthony J. Piccolo, PA-C

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 unpaid 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, I understand that I am responsible for any associated fees as well as the balance due. 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

- |   |                                   |  |                                     |
|---|-----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Nasal blockage | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Itchy nose |
| <input type="checkbox"/> Itchy eyes     | <input type="checkbox"/> Headache | <input type="checkbox"/> Ear problems    | <input type="checkbox"/> Other:     |

When are you symptomatic:  Winter  Spring  Summer  Fall

Medications taken and their effects:

_____	_____
_____	_____
_____	_____

Suspected or known causes of these symptoms:

- |                                |                                |  |                                 |
|--------------------------------|--------------------------------|--|---------------------------------|
| <input type="checkbox"/> Colds | <input type="checkbox"/> Weeds | <input type="checkbox"/> Dust            | <input type="checkbox"/> Latex  |
| <input type="checkbox"/> Trees | <input type="checkbox"/> Cats  | <input type="checkbox"/> Mold            | <input type="checkbox"/> Foods: |
| <input type="checkbox"/> Grass | <input type="checkbox"/> Dogs  | <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> 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:**

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