Allergy Consultants, P.A.

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

• David A. Fost, M.D. • Anthony J. Piccolo, PA-C • Amanda N. Godine, 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 **HEIGHT**_____ **WEIGHT**_____

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 _____ Cell Phone _____

FAMILY DOCTOR / PRIMARY CARE PHYSICIAN

Name / Practice: _____ Practice Phone Number: _____

Practice Address: _____

Pharmacy: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

RESPONSIBLE PARTY / POLICY HOLDER INFORMATION

Name _____ Relationship _____ D/O/B: _____ SS# _____ - _____ - _____

Address _____ Cell Phone Number: _____

City _____ State _____ Zip Code _____

POLICY HOLDER EMPLOYER

Company Name _____

Address _____ Phone Number _____

City _____ State _____ Zip Code _____

MEDICAL 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 Referral Required ❒ yes ❒ no

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 co-pay 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 for collection, I agree to be responsible for the payment of any collection fees. 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.

I understand that telemedicine is the practice of delivering clinical healthcare services via technology assisted media or other electronic means between a practitioner and/or clinical staff and a patient who are located in two different locations. _____yes _____no

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:_____

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 your 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: _____

_____

Name of Patient: _____ Date: _____

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

Name of Patient: _____ Date: _____

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					

Name of Patient: _____ Date: _____

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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