BEACH ALLERGY & ASTHMA SPECIALTY GROUP

PEDIATRIC AND ADULT ALLERGY & CLINICAL IMMUNOLOGY
STEVEN MELTZER, M.D., MBA
FONDA JIANG, M.D.

Welcome to our practice.

We are pleased to welcome you to Beach Allergy & Asthma Specialty Group, and look forward to providing you with comprehensive allergy and asthma care.

Our staff and doctors make every effort to be timely and we do not double book your appointment time. In order to accommodate the scheduling needs of all patients, kindly confirm your appointment by phone at (562) 496-4749 or by email at least 2 business days prior to your appointment.

Appointment Cancellation and Rescheduling Policy

Notification to reschedule or cancel an appointment must be received in our office at least *two business days* prior to your appointment.
Failure to do so will result in a $25 fee.

Please be considerate of other patients. Do not eat/snack while in the office. Refrain from using scented lotions/perfumes when visiting our office as these may trigger reactions in some of our patients. Additionally, refrain from using your cell phone while in the office as it is distracting to our staff and other patients.

Please bring your insurance card and photo I.D. to your first visit. It is your responsibility to make sure that we have the most current insurance information on file for you. A statement will be sent to you only if there is an outstanding balance due after your insurance has paid its portion of the claim.

Co-pays, co-insurance and unmet deductibles are due at the time that services are provided. Please be prepared to take care of your financial responsibility at the time of your visit. You will be informed of your responsibility for skin testing prior to the procedure being performed.

Communication: Please provide us with an e-mail address and current smart phone cell number.

Obtaining diagnostic results: Please do not call the office to review or obtain lab results; these results will be reviewed at the time of your next visit with the doctor. Our nurses and office staff are not trained to interpret lab or radiology results.

After the Initial Visit: All follow up visits are done remotely via TeleHealth. You will not be returning to our office. You must have a smart phone or internet access for this visit. We will provide you with further instructions when we schedule your next visit.

3816 Woodruff Ave, Suite 209, Long Beach, California 90808 Phone: 562-496-4749 Fax: 562-429-3329
www.beachallergy.com

Beach Allergy & Asthma
Specialty Group

NAME_____ BIRTHDATE_____ DATE_____

ADDRESS_____ BIRTHDATE_____ SEX_____ AGE_____

CITIES OF RESIDENCE AND DATES OCCUPATION_____

_____ HOBBIES_____

IF PATIENT IS A CHILD: FATHER: AGE_____ OCCUPATION_____

MOTHER: AGE_____ OCCUPATION_____

A. **MAJOR REASON FOR REFERRAL:** 1) hayfever 2) sinus 3) ear problems 4) asthma 5) bronchitis/cough 6) eye problems 7) GI problems 8) hives/skin rashes 9) eczema 10) drug reaction 11) insect reaction 12) recurrent infection

Other_____

B. Please detail your most distressing allergy symptoms. Describe your symptoms as to HOW LONG and HOW SEVERE they are. Do you suspect any specific trigger factors?

_____

_____

_____

_____

_____

_____

_____

_____

C. **Medications for Allergy:**

	Med Name	Dose	Daily Frequency	Does it help?	Side effects
1.					
2.					
3.					
4.					
5.					
6.					

List other current medications/therapies that you use often: _____

_____

Previous Allergy Treatment: Skin Tests Blood Tests Positive to: Pollens Dust Animals Mold Foods

Allergy Shots: No Yes Dates: From_____ to _____ Did it help? None Some Much improvement

Has patient ever taken oral/injectable steroids? _____ Last dose?_____

D. **MEDICAL HISTORY:** General Health: Excellent Good Fair Poor

Hosptializations: Reason, Date, Place

Other Medical Problems

_____ _____

_____ _____

_____ _____

Surgical History: Tonsillectomy Adenoidectomy Sinus Surgery PE tubes Polyps Chest Surgery

Other:_____

_____

Review of Systems: Please circle items below that apply to your condition and the severity.

Frequent Headache: Mild Mod Severe: Frontal Sides Back Throbbing Squeezing Relief with meds?

Ear Problems: Mild Mod Severe : Itch Drainage Blockage Frequent Infxs Hearing Loss Middle Ear Fluid

Eye Problems: Mild Mod Severe: Red Itch Tear Swelling Pain Discharge Vision Change?

Nasal Problems: Mild Mod Severe: Sneeze Itch Sniffles Watery Discharge Colored Discharge Congestion Sinus Infections Snoring Nose Bleeds Post Nasal Drip Polyps Loss of Smell Nasal or Sinus Surgery

Mouth/Throat: Soreness Throat Clearing Frequent Infx Scratch Throat Voice Changes Difficulty Swallowing

Asthma: Mild Mod Severe: **Wheezing Freq:** Daily Weekly Monthly Wheeze with Activity Sleep Disturbance

Albuterol Use Freq _____ER/UC visits past year_____ Missed School/Work Days/Past year_____

Hospitalizations for Asthma/Pneumonia: List dates and hospital_____

_____ Abnormal Chest X-Ray: _____

Chronic Cough: How Long?_____ Frequency_____ Phlegm Y N Color?_____

Daytime Nightime Chest Pain? Dizzy Spells? Palpitations?_____

Smoking History: Present Past Cigarettes Vaping Cigar Packs Per Day_____ How Long?_____

If quit, when?_____

Frequent Choking, Vomiting, Difficulty Swallowing:_____

Stomach or Intestinal Problems: Heartburn Appetite Loss Nausea Vomiting Abdominal Pain Stool Changes

Bloody Stools Diarrhea _____

Eczema, Hives, or Swelling: Frequency_____ Duration of Episodes_____

Relief with Antihistamines/Steroids_____ Associated changes Urine Stool Joint Swell

Trigger Factors: Soap/Detergent Cosmetics Jewelry contact Sun Cold Activity Stress Meds Foods

Other skin problem, rash:_____

Insect Allergy: Bee Yellow Jacket Hornet Wasp Other Describe Reactions and Dates _____

_____

Food Alllergy: Milk Eggs Wheat Fish Shellfish Chocolate Peanut Other Nuts Describe Reactions and Dates

_____

Drug Allergy: Penicillin Aspirin Sulfa X-ray Dyes NSAIDs Anesthetics Describe Reactions and Dates

_____

AGGRAVATING FACTORS: Please mark the factors that make your allergy symptoms **WORSE**. If the item does not affect your symptoms, please leave it blank.

	HAYFEVER	SINUS	EYES	ASTHMA/BRONCHITIS	HIVES/ECZEMA	OTHER
SAME ALL YEAR						
JANUARY						
FEBRUARY						
MARCH						
APRIL						
MAY						
JUNE						
JULY						
AUGUST						
SEPTEMBER						
OCTOBER						
NOVEMBER						
DECEMBER						
MORNING						
AFTERNOON						
EVENING						
NIGHT						
COLD						
HEAT						
WIND						
RAIN/FOG						
SMOG						
HOUSE DUST						
MOWED GRASS						
YARD/PARK						
WEEDS						
TREES						
ANIMALS						
TOBACCO SMOKE						
COSMETIC ODORS						
AIR CONDITIONER						
WORSE AT HOME						
WORSE AT WORK/SCHOOL						
WORSE ON TRIPS						
FATIGUE						
RUNNING						
LAUGHTER						
TENSION/EXCITEMENT						
COLD						
ALCOHOLIC BEVERAGES						
ANTHISTAMINES						
PREGNANCY						
MENSTRUAL PERIODS						

RELIEVING FACTORS: List factors that make symptoms **BETTER** (not including medications). E.g. trips to mountain or ocean.

Hayfever, sinus, eyes:_____

Asthma, bronchitis:_____

Hives, eczema: _____

Other symptoms:_____

Family History: Any family members with the conditions below? List numbers on the line next to the affected relative.

Patient's mother _____
Patient's father _____
Patient's brothers _____
Patient's sisters _____
Patient's maternal grandparents _____
Patient's maternal aunts/uncles _____
Patient's paternal grandparents _____
Patient's paternal aunts/uncles _____

1. Hayfever
2. Sinus Disease
3. Asthma
4. Hives/Swelling
5. Eczema
6. Food Allergy
7. Drug Allergy
8. Insect Allergy
9. Heart Disease
10. Diabetes
11. Serious/Recurrent Infection
12. Other

Social/Environmental: House Apartment Condo Other What city? _____ How long? _____

Unusual Exposure: Mildew Water Damage Pests

Pets in Household and how long? Cat_____ Dog _____ Other _____

Other animals patient is exposed to regularly _____

Smokers in household? _____

Patient's Bedroom: Mattress: Regular Foam Water Plastic-Covered Other _____

Pillows: Polyjester Foam Feather Plastic-Covered Other _____

Floors: Carpet Hardwood Tile Area Rug Other _____

Dust Controls: Air Purifier Mite-Proof Encasings No Stuffed Animals Bedding Wash Hot Water

Work Exposure: Dust Chemicals Fumes Mold Occupation_____

BEACH ALLERGY & ASTHMA SPECIALTY GROUP

STEVEN MELTZER, M.D.,MBA

FONDA JIANG, M.D.

PATIENT INFORMATION (Please complete legibly)

Name (Last, First, Middle)		Nickname/A.K.A.	Age	Birth Date
☐ Male ☐ Female Height: Weight:	Email		SSN# of Patient	
Home Street Address (P.O. boxes are not acceptable)		Primary Phone # ☐ cell ☐ home ☐ work		
City	State / Zip Code	Secondary Phone # ☐ cell ☐ home ☐ work		
Occupation	Employer	Employer Phone #		
Preferred Pharmacy Name	Preferred Pharmacy Address	Preferred Pharmacy Phone		

Race/Ethnicity ☐ White (Not of Hispanic origin) ☐ Black (Not of Hispanic origin)
☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other:_____ ☐ Decline to state

INSURED PARTY– If not self

Name (Last, First, Middle Initial)		Patients' Relationship to Insured	Birth Date	SSN# of Insured
Home Street Address (P.O. boxes are not acceptable)		Primary Phone #		
City	State / Zip Code	Secondary Phone # ☐ home ☐ work		

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Effective Date	Subscriber/I.D. #	Group #

SECONDARY INSURANCE INFORMATION (if applicable)

Secondary Insurance Company	Effective Date	Subscriber/I.D. #	Group #

PRIMARY CARE PHYSICAN AND REFERRAL INFORMATION

Name of Primary Care Physician	Name of Referring Doctor	Referral Source (If Other Than Doctor) ☐ Website/Search Engine (Please write URL): ☐ Family/Friend (Please include name): ☐ Insurance Company Referral

EMERGENCY CONTACT

Emergency Contact Name (Last, First)	Telephone #	Relationship

FINANCIAL AGREEMENT- READ BEFORE SIGNING

RELEASE OF MEDICAL RECORD In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and /or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION I authorize any holder of medical and other information about me to release to Medicare and its agents, an insurance company, any other third party payer, a state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by my insurance company. If my insurance requires a prior authorization for services, I understand that it is my responsibility to ensure that I attain prior authorization for all visits, including allergy shots.

Signature_____ **Relationship to Patient** _____ **Date** _____

Patient or person authorized to consent for patient (If signing for minor)

BEACH ALLERGY & ASTHMA SPECIALTY GROUP
STEVEN MELTZER, M.D., FONDA JIANG, M.D.,

Notice of Privacy Practice

Can confidential messages (i.e. appointment reminders, lab results, x-ray results) be left on your telephone answering machine or voice mail? ☐ **Yes** ☐ **No**

Please list any family members or persons with whom we may discuss your medical chart with:

Name	Relationship
Name	Relationship
Name	Relationship

When you ask us to fax information to you, it is your responsibility to make sure that the fax number is correct and your confidential information will not be read by anyone else.

You are fully aware that a cell phone is not a secure and a private line.

By signing below, you acknowledge that you have received a copy of this office's Notice of Privacy Practices and authorize all of the above information.

Patient's Name	Date
Signature (Guardian's if under 18 years)	Relationship

ACKNOWLEDGMENT OF FINANCIAL POLICY

- I understand that is my responsibility to verify my insurance policy coverage prior to an office visit and to confirm that Beach Allergy and Asthma Specialty Group (BAASG) is in-network with my plan. As a courtesy, (BAASG) will bill my insurance plan for office visits and procedures.

- It is my responsibility to verify that BAASG has my most current insurance information on file, including secondary coverage, and understand that any charges not reimbursed by my plan because of missing or outdated insurance information shall remain my immediate responsibility.

- It is my responsibility to notify the business office of any change in my insurance coverage before an appointment date. If I fail to notify the office of a change in my insurance coverage, it is possible that charges incurred after the effective date of the policy change may not be covered and I will be responsible for these charges.

- **Copays, coinsurance, and unmet deductibles are due at the time service are rendered.** All services not covered or approved by the insurance carrier remain my immediate responsibility. Upon request, an estimate of my financial responsibility for skin testing and immunotherapy will be provided prior to the procedure being performed. I understand that this is only an estimate and that I may elect to verify coverage with my plan prior to service being provided. My estimated financial responsibility is due at the time services are provided.

- **Pay options:** As a convenient alternative, I may provide BAASG with a credit, debit, or HSA card and authorize BAASG to charge the card on file for payment of the portion of services that my insurance company deems as my responsibility. Charges to my card shall be processed after the claim has been processed by my insurer and the insurance portion of the payment has been paid and posted to my account.

- I understand that some insurance carriers require precertification for diagnostic testing/lab work done outside of the office (CT scans, x-rays and "blood work"). It is my responsibility to verify with my insurance carrier prior to having the studies performed and to determine if a certain laboratory or x-ray facility must be used. (The BAASG office will help you as much as possible with this information, please note that policy coverage for procedures performed outside of the office can change without our office being notified).

- For Medicare patients only: I understand that the BAASG physicians are Medicare providers and will submit all claims to my insurance carrier. I understand that I will be responsible for annual deductibles and applicable copays.

- BAASG is not a Medi-Cal contracted provider. If I elect to be seen by BAASG I will be responsible for payment of service.

- For patients with HMO insurance only: I understand that my insurance may only pay for services if prior authorization has been obtained for each visit. If I choose to be seen by the physician without the necessary authorization, I understand that I will be responsible for the charges.

- For patients with a POS option only: I understand that if I elect to use my POS option, I must continue to use this option for all future visits. I understand that I cannot switch back to my HMO plan and expect to get authorizations for completed visits and procedures.

- **Notification to reschedule or cancel an appointment must be received by BAASG at least two business days prior to the appointment. Failure to do so may result in a $25.00 fee.**

_____ _____

Signature (patient or parent/guardian where applicable) Date

_____

Print name