ASSOCIATED FAMILY PHYSICIANS
OF BOCA RATON, P.L.

MARILYN B. CABRAL
Administrator

MEDICAL STAFF

LYNDA ALTMAN, M.D., F.A.A.F.P.
Board Certified in Family Medicine

OWEN A. BARRUW, M.D., F.A.C.P.
Board Certified in Internal Medicine

DUSHYANT J. UTAMSINGH, M.D., PA.
Board Certified in Internal Medicine

RADHIKA PHADKE, M.D., Ph.D.
Board Certified in Endocrinology

Date: _____

Patient's Name : _____ Marital Status : _____

Address : _____ Date of Birth: _____

City: _____ Age : _____ Sex : M F

State: _____ Zip Code : _____-- _____

Race: O Caucasian O Black O Hispanic O Asian O Native American O Asian Pacific American
O Pacific Islander O Subcontinent Asian American O American Indian or Alaskan Native
O Native Hawaiian O Black Non-Hispanic O White Non-Hispanic
O Other Race or Ethnicity

Ethnicity: O Latino / Hispanic O Other O Not Reported / Refused

Home Phone : ( ) _____-- _____

Cell Phone: ( ) _____-- _____

Referred By : _____ Employed : Y / N Student : Y / N Retired: Y / N

Drivers License
(Please give drivers license to receptionist)

Employer: _____

Address: _____

_____ -- _____
City State Zip Code

Other Address: _____
(if applicable)

City: _____ State: _____ Zip Code: _____-- _____

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

Please Present Card To Receptionist

Below information is relating to **subscriber** (insured, not necessarily patient):
CHECK BOX IF SAME AS ABOVE
Relationship to subscriber: _____ self _____ spouse _____ child _____ other (pls. explain)

NAME OF SUBSCRIBER: _____

DATE OF BIRTH : _____

SUBSCRIBER'S ADDRESS: _____

_____ _____ -- _____
City State Zip Code

SUBSCRIBER'S EMPLOYER : _____

EMPLOYER'S ADDRESS: CHECK BOX IF SAME AS ABOVE

_____

_____ _____ -- _____
City State Zip Code

9910 SANDALFOOT BLVD., SUITE 1, BOCA RATON, FLORIDA 33428-6692
TELEPHONE (561) 883-3030 • FACSIMILE (561) 852-7611
www.afpdocs.org

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Board Certified in Endocrinology

Patient's Name : _____

SECONDARY INSURANCE (if applicable)
INSURANCE COMPANY NAME: _____
Please Present Card To Receptionist
Below information is relating to **subscriber** (insured, not necessarily patient):
CHECK BOX IF SAME AS ABOVE

Relationship to subscriber: _____ self _____ spouse _____ child _____ other (pls. explain)

NAME OF SUBSCRIBER: _____

HOME # ( ) _____ -- _____ DATE OF BIRTH : _____

SUBSCRIBER'S ADDRESS : _____

_____ _____ -- _____
City State Zip Code

SUBSCRIBER'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

_____ _____ -- _____
City State Zip Code

PLEASE BE CONSIDERATE. FAILURE TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF APPOINTMENT TIME WILL RESULT IN A $ 25.00 FEE.
Do you have a Health Care Surrogate? Y / N **If yes please furnish a copy for your medical record.**
Do you have a living will? Y / N **If yes please furnish a copy for your medical record. If you would like literature on Advance Directives please ask your Health Care Provider.**
Primary Language Spoken: ( ) English ( ) Spanish ( ) French ( ) Other _____

Name of an emergency contact: _____

Phone number ( ) _____ -- _____

Relationship _____

Payment is required at the time services are rendered.

LIFETIME AUTHORIZATION
I, authorize the healthcare providers and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary. I guarantee payment of any and all charges for services provided.

_____
SIGNATURE OF PATIENT (authorized person if minor) DATE

Relationship if Minor: _____

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Today's date _____ **2022**

PLEASE LET US KNOW HOW YOU WOULD LIKE CONFIDENTIAL MEDICAL INFORMATION CONVEYED TO YOU?

Call home phone ( ) _____
Can we leave medical information on your answering machine / voicemail? Yes or NO

Call cell phone ( ) _____
Can we leave medical information on your answering machine / voicemail? Yes or NO

Can we leave medical information with a designated person? Yes or NO
If yes, please give us the individual's complete name, date of birth and relationship:

_____
Name date of birth Relationship

By signing, below I understand this authorization form to release confidential information will remain in effect until I revoke the authorization in writing.

_____
Patient's Name (Guardian if minor)

_____
Patient's Signature (Guardian if minor) Date

LOCAL PHARMACY

NAME: _____ PHONE # ( ) _____

MAIL ORDER PHARMACY

NAME: _____ PHONE # ( ) _____

Confidential medical information form.docx

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ASSOCIATED FAMILY PHYSICIANS
OF BOCA RATON, P.L.

Patient Medical History **Today's Date:**_____

Name:_____ **Date of birth:**_____

□Y □N Migraine Headache
□Y □N Eye Disorders
□Y □N Chronic Obstructive Pulmonary Dx
□Y □N Asthma
□Y □N Tuberculosis
□Y □N Coronary Artery Dx
□Y □N Acute Myocardial Infarction
□Y □N Essential Hypertension
□Y □N Hyperlipidemia
□Y □N Atrial Fibrillation
□Y □N Stroke Syndrome
□Y □N Heartburn
□Y □N Ulcers
□Y □N Crohn's Disease
□Y □N Ulcerative Colitis
□Y □N Irritable Bowel Syndrome
□Y □N Hepatitis B
□Y □N Hepatitis C
□Y □N HIV Infection
□Y □N Diabetes Mellitus
□Y □N Thyroid Disorder

□Y □N Renal Disorders
□Y □N Prostate Disorders
□Y □N Gout
□Y □N Osteoarthritis
□Y □N Osteoporosis
□Y □N Neurologic Disorders
□Y □N Seizure Disorder
□Y □N Alzheimer's Dementia
□Y □N Psychiatric Disorders
□Y □N Depression
□Y □N Anxiety Disorder
□Y □N Anemia
□Y □N Cancer

Other:_____

Other:_____

Other:_____

Patient Social History

Substance Use

□Y □N Alcohol Use
□Y □N Tobacco Use
□Y □N Vape Use
□Y □N Previous History of smoking
□Y □N Previous History of vaping
□Y □N Drug Use
□Y □N Coffee
□Y □N Caffeine Use

Relational

□Y □N Single
□Y □N Living with Significant Other
□Y □N Marital History
□Y □N Divorced
□Y □N Widow

Other:_____

Name:_____ **Date of Birth:**_____

Living Conditions
□Y □N Living with parents
□Y □N Caretaker of another person
□Y □N Resides in AFL
□Y □N Living Alone
Other:_____

Other Social History
Primary Language:_____
□Y □N Work
Occupation:_____
□Y □N Student
□Y □N Travel _____
□Y □N Seatbelt Use
□Y □N Smoke Detectors
□Y □N Firearm Safety Awareness

Surgical History	**Date**		**Date**
□Y □N Reported Prior Surgical	_____	□Y □N Appendectomy	_____
□Y □N Adverse Reaction Anesthesia		□Y □N Cholecystectomy	_____
□Y □N Cataracts	_____	□Y □N Hernia Repair	_____
□Y □N Tonsillectomy	_____	□Y □N Orthopedic Surgery	_____
□Y □N Thyroid Surgery	_____	□Y □N Knee Replacement	_____
□Y □N Lung Surgery	_____	□Y □N Total Hip Replacement	_____
□Y □N Coronary Artery Bypass	_____	□Y □N TURP	_____
□Y □N Heart Valve Replacement	_____	□Y □N Prostatectomy	_____
□Y □N Pacemaker Placement	_____	□Y □N Breast Augmentation	_____
□Y □N AAA Repair	_____	□Y □N Lumpectomy	_____
□Y □N Varicose Vein Ligation	_____	□Y □N Mastectomy	_____
Other:_____		□Y □N Cesarean Section	_____
		□Y □N Hysterectomy	_____
Other:_____		□Y □N Tubal Ligation	_____

Preventative

	Date		**Date**
Mammogram	_____	Pap Smear	_____

Colorectal Screening
Fecal Occult Blood____
Sigmoidoscopy____
Colonoscopy _____
Cologuard _____

Other Preventative

EKG	_____
AAA/US____	_____
Chest Xray(CXR)	_____
Bone Density	_____
PSA	_____
Other:	_____

Vaccinations

Td Vaccine	_____
Tdap Vaccine	_____
Zostavax Vaccine	_____
Shringrix	_____
Pneumonvax	_____
Prevnar	_____
Hepatitis B Vaccine	_____
Pfizer Vaccine dose 1	_____
Pfizer Vaccine dose 2	_____
Moderna Vaccine dose1	_____
Moderna Vaccine dose 2	_____
Johnson & Johnson Vaccine	_____

Name:_____ **Date of birth:**_____

Today's Date _____

LOCAL PHARMACY

NAME: _____ PHONE # ( ) _____

MAIL ORDER PHARMACY

NAME: _____ PHONE # ( ) _____

Allergies ☐ Yes ☐ No

What are you allergic to?	Type of reaction
What are you allergic to?	Type of reaction
What are you allergic to?	Type of reaction

CURRENT MEDICATIONS:

☐ **None**

NAME OF MEDICATION	Dose	How taken?

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Only complete if you are on Medicare or Medicare Advantage

To Our Valued Patients:

Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know that all of our employees, managers, and doctors continually undergo training so t hat they may understand and comply with government rules and regulations regarding Medicare. We strive to achieve the very highest standards of ethics and integrity in performing services for our Medicare patients.

It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper Medicare expenditures. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any Medicare service or billing errors.

Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any billing or service problem so that we may remedy the situation promptly.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION
(SIGNATURE ON FILE)

NAME OF BENEFICIARY (PATIENT) _____ MEDICARE NUMBER _____

"I request that payment of Medicare benefits be paid on my behalf to the Provider of medical services, for services provided to me. I authorize the release of medical information about me to the Health Care Financing Administration and it's agents, any information needed to determine benefits payable for these services.

I understand my signature requests that payment be made directly to the Provider of medical services. I authorize the release of medical information necessary to pay the claim. In Medicare assignment cases, I understand that I am responsible for my annual deductible, Co-insurance (20% of the approved amount), and any non-covered services provided to me. All other charges will be adjusted off. I understand the amount of payment I'm responsible for is due at the time services are rendered."

PATIENT'S SIGNATURE _____ DATE _____

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Patients: By dating and signing below this will help us coordinate your health care with other health care providers.

I, authorize any Physician, Hospital, Diagnostic Facility, Health Provider, or Insurance Carrier to release any information on my behalf to Associated Family Physicians of Boca Raton, P.L.

Print Patient's Name _____ Date of Birth _____

Patient's Signature (Guardian if minor) _____ Date _____

I, authorize Associated Family Physicians of Boca Raton, P.L. to release any information on my behalf to any Physician, Hospital, Diagnostic Facility, Health Provider, or Insurance Carrier.

Print Patient's Name _____ Date of Birth _____

Patient's Signature (Guardian if minor) _____ Date _____

I, authorize Associated Family Physicians of Boca Raton, P.L., their doctors and employees to release any medical information on my behalf to the following: (e.g. family members)

1. Print Name _____ Relationship _____

2. Print Name _____ Relationship _____

Print Patient's Name _____ Date of Birth _____

Patient's Signature (Guardian if minor) _____ Date _____

file: release of medical information

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LIFETIME AUTHORIZATION

" I authorize the release of any medical information necessary to process a claim or any insurance related claim made on my behalf. I assign the benefits payable for services to the healthcare provider furnishing the services. I authorize such healthcare provider to submit a claim to my insurance company on my behalf." I authorize the healthcare provider and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary.

A photocopy of this authorization shall be considered as effective and valid as the original.

_____
PATIENT'S NAME

X_____
PATIENT'S SIGNATURE (authorized person if minor) DATE

Authorization forms

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

HEALTHCARE PROVIDER'S NAME:

Phone Number: ( ) _____

Fax Number: ( )

Email: _____ @ _____

I, hereby authorize you to release medical records and / or any information including diagnosis or any treatment or examination rendered to include any condition or diagnosis relating to Alcohol Abuse, Drug or substance Abuse, HIV testing or Results, or Mental Health Conditions. Please include other Physician's medical records.

Patient: _____

Date of Birth: _____

X ----------

Signature of Patient (Parent or guardian of minor child) Date

☐ Send all records to:

Associated Family physicians of Boca Raton, P.L.
9910 Sandalfoot Blvd., Suite 1
Boca Raton, FL 33428-6692
561-883-3030 - 561-852-7611 fax

☐ Lynda Altman, M.D., F.A.A.F.P.
☐ Dushyant J. Utamsingh, M.D.
☐ Tabitha M. Dugal, FNP-C
☐ Arlande R. Prince, FNP-BC
☐ Owen A. Barruw, M.D.,F.A.C.P.
☐ Radhika P. Phadke, M.D., Ph.D.
☐ Gabriela Lopez Botero, PA-C

Date: _____

PATIENT PORTAL YOU WILL BE ABLE TO:

- **Securely message your care team**
- **Review appointments**
- **Request prescription refills or view lab results**
- **Send your records to other healthcare providers**
- **Log in from any web browser, including mobile**

IF YOU WISH TO BE ABLE TO ACCESS OUR PATIENT PORTAL PLEASE COMPLETE THE FOLLOWING.

PRINT YOUR COMPLETE NAME BELOW

ENTER YOUR DATE OF BIRTH

__-__-____

ENTER YOUR PREFERRED EMAIL ADDRESS

ASSOCIATED
FAMILY
PHYSICIANS
OF BOCA RATON, P.L.

Account # _____

Dear Patients:

We will be use an automated system for appointment confirmations and appointment recalls. Please let us know how you would like to be contacted.

Please select only one option.

Print Name:

Text Message: ◯ yes ◯ no

If yes, what phone number: ( ) _____ - _____

Email: ◯ yes ◯ no

If yes, your email:

Phone Number: ◯ yes ◯ no

If yes, what phone number: ( ) _____ - _____

( ) _____ - _____

9910 Sandalfoot Blvd., Suite 1 Boca Raton, FL 33428-6692
561-883-3030 * fax 561-852-7611 * www.afpdocs.org

ASSOCIATED
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OF BOCA RATON, P.L.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Associated Family Physicians of Boca Raton, P.L. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for:

Associated Family Physicians of Boca Raton, P.L.

9910 Sandalfoot Blvd., Suite 1

Boca Raton, FL 33428-6692

561-883-3030

Name of Patient (Please Print)

Signature of Patient

Date

Signature of Patient's Representative (Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

ASSOCIATED FAMILY PHYSICIANS OF BOCA RATON, P.L.
9910 SANDALFOOT BLVD., SUITE 1
BOCA RATON, FL 33428-6692
561-883-3030

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

MARILYN B. CABRAL	561-883-3030	hipaa@afpdocs.org
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Name_____ Date_____

Do I Need a Test For PAD?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? ☐
2. Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet? ☐
3. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep? ☐
4. Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal? ☐
5. Do you have diabetes and unusual hair loss or skin discoloration in your legs? ☐
6. Do your fingers or toes feel numb or cold in response to temperature changes or stress? ☐
7. Have you suffered a severe injury to your leg(s) or feet? ☐
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? ☐
9. Have you had blockages in your coronary or heart arteries? ☐

Other Comments or Notes: _____

_____

_____

Patient Signature:_____ Date:_____

Note: *Providers are advised that insurance carriers have policies regarding when diagnostic services are considered medically necessary. These policies may vary between carriers and are subject to change at any time. Providers should check coverage requirements with specific insurance plans before testing.*

ALLERGY PROFILE

Name: _____ Phone: _____ DOB: _____ Date: _____

Please check all symptoms that you experience occasionally or more than once a day:

☐Sneezing ☐Runny Nose ☐Postnasal Drip ☐Hives/Rash ☐Vomiting
☐Headaches ☐ Itchy/Watery eyes ☐ Wheezing ☐ Cough ☐Diarrhea
☐Nasal Congestion ☐Shortness of Breath ☐ Itching ☐ Swollen lips, tongue, face, etc.

Have you tired over the counter allergy medication(s)? (Antihistamines, Decongestants):

☐Yes ☐No Which medications have you tried? _____

Have you ever been allergy tested? ☐Yes Date: _____ ☐No

----------**PHYSICIAN USE ONLY**----------

Physician Recommendations: ☐ Allergy Testing ☐ No recommendation

☐ **Allergic Rhinitis Unspecified** j30.9
☐ **Chronic Rhinitis** j31.0
☐ **Urticaria – Idiopathic** L50.1
☐ **Urticaria – Allergic** L50.0
☐ **Sinusitis Chronic (NOS)** J32.9
☐ **Allergic Conjunctivitis** H10.45
☐ **Rash** R21
☐ **Atopic Dermatitis** L20.81
☐ **Angioedema** T78.3 A D S
☐ **Allergic Gastro** K52.2
☐ **Asthma Mild Persistent** J45.30
☐ **Asthma Mild Intermittent** J45.20
☐ **Asthma Moderate Persistent** J45.40
☐ **Asthma Other** J45.998

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☐ *Gabriela Lopez Botero, PA*
☐ Other: _____

X_____ X_____

Provider Signature **Documented in Chart**