

Allergy Consultants, P.A.

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

Arthur F. Fost, M.D. ♦ David A. Fost, M.D.

PATIENT INFORMATION

DATE _____

Patient's Name _____
Last First
Date of Birth ____/____/____
Address _____ Home Phone _____
City _____ State _____ Zip Code _____
E-mail address _____ Social Security # _____

Marital Status S M W D SEP

Spouse's Name _____ Date of Birth ____/____/____

Emergency Contact _____ Relationship _____
Home Phone _____ Work Phone _____

Family Doctor/Primary Care Physician _____
Address _____
Phone Number _____

Referred By _____

RESPONSIBLE PARTY/SUBSCRIBER INFORMATION

Name _____ Relationship _____ DOB _____ SS# _____
Address _____ Phone Number _____
City _____ State _____ Zip Code _____

EMPLOYMENT INFORMATION

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 Referral Required Yes No

Allergy Consultants, P.A.

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

Arthur F. Fost, MD ♦ David A. Fost, MD ♦

ALLERGY HISTORY FORM

Name of Patient: _____ Age: _____

Referred By: _____ Primary Physician: _____

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

NASAL AND EYE SYMPTOMS

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

CIRCLE 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

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

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

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

BASEMENT:

 None Finished Unfinished History of water leakage

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

Air conditioning? None Window Central

Description of bedroom: Neat Cluttered Dusty Stuffed toys

Please describe the **TYPE OF WORK** or **DAILY ACTIVITY**:

 Office setting Outdoor 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:

Allergy Consultants, P.A.

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

Arthur F. Fost, M.D. ♦ David A. Fost, M.D. ♦ Antonio A. de la Cruz, M.D.

Notice of Privacy Practices

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

WWW.SNEEZEDOCTORS.COM

197 Bloomfield Avenue
Verona, NJ 07044
(973) 857 – 0330
Fax (973) 857 – 0980

5 Franklin Avenue
Belleville, NJ 07109
(973) 759 – 2029
Fax (973) 759 – 0403

89 Sparta Avenue
Sparta, NJ 07861
(973) 726 – 8850
Fax (973) 726 – 8924

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Allergy Consultants P.A., Gail Carter, Manager, 197 Bloomfield Avenue, Verona, NJ 07044 (fax 973-857-0980).
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Allergy Consultants, P.A. Gail Carter, Manager, 197 Bloomfield Avenue, Verona, NJ 07044 (fax 973-857-0980). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact Allergy Consultants, P.A. Gail Carter, Office Manager, 197 Bloomfield Ave. Verona, NJ 07044 (tel 973-857-0330)
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Allergy Consultants, P.A. Gail Carter, Manager, 197 Bloomfield Ave., Verona, NJ (tel 973-857-0330). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Allergy Consultants, Gail Carter, Manager, 197 Bloomfield Ave, Verona, NJ 07044 (tel:973-857-0330).

Allergy Consultants, P.A.

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

Arthur F. Fost, M.D. ♦ David A. Fost, M.D.

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.
2. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due Allergy Consultants agree to pay all cost of collections including collection agency fees. I understand there is a \$10.00 returned check fee should a check be returned for any reason.
3. 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 the payment of my treatment.
4. I also direct and assign payment from said third parties to Allergy Consultants. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to Allergy Consultants for any charges not covered by insurance. If payment from my insurance is not received within 120 days, my account will become due and payable by me. Any balance remaining on the account after insurance pays will be due payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not payable by my insurance carrier are due immediately.
5. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or body fluids. In the event of such direct exposure, State laws require a sample of my blood to be tested for the presence of infectious diseases. The results of these tests will be released to me and my family and to the healthcare workers who suffered exposure.
6. The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon me both for the present treatment and that which may be rendered to me and my family in the future by Allergy Consultants.
7. I authorize a copy of my Allergy Consultants medical record to be forwarded to my Primary Care Physician as well as any and all attending or consulting practitioners.

Signature of Patient/Responsible Party: _____

Relationship to Patient: _____ Date _____

Witness: _____ Date _____

I hereby acknowledge that I have been presented with a copy of Allergy Consultant's notice of Privacy Practice.

Signature _____ Date: _____

Printed Name of Patient _____

Source: Advocacy Resource Center of the American Medical Assn/ October 1999