

Allergy Consultants, P.A.

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

Arthur Fost, M.D. • David Fost, M.D. • Antonio de la Cruz, M.D. • Mark Weinstein, M.D.

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)

Spouses 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 authorized treatment by Allergy Consultants.
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 payor 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 your insurance company require a specialist referral from your primary care physician before you can be seen by our physicians, it is your responsibility to obtain that referral prior to your appointment. Our contracts with the insurance companies prohibit us from seeing you without a referral and billing them for services. In the event that services are provided and your insurance is not in effect that day, or if your contract contains a pre-existing clause remember that you, the patient/guarantor are responsible for payment.
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 to a collection agency and/or attorney for collection, I agree to be responsible for the payment of an additional collection fee in an amount equal to 30% of my outstanding balance, inclusive of accrued interest. I also understand there is a \$15.00 returned check fee should, a check be returned for any reason.

Signature of Patient/Responsible Party

I hereby acknowledge that I have been presented with a copy of Allergy Consultants notice of financial policy/guarantor agreement.

Signature _____

Relationship to Patient _____

Date _____

Printed Name of Patient _____

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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: