

Allergy Consultants, P.A.

Specialist in Pediatric and Adult Allergy, Asthma, and Sinus Disease
Arthur Fost, M.D. • David Fost, M.D. • Anthony J. Piccolo, 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 _____ Work phone _____

FAMILY DOCTOR / PRIMARY CARE PHYSICIAN

Name / Practice: _____ Practice Phone Number: _____

Practice Address: _____

RESPONSIBLE PARTY / POLICY HOLDER INFORMATION

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

Address _____ Cell Phone Number: _____

City _____ State _____ Zip Code _____

POLICY HOLDER EMPLOYER / PATIENT EMPLOYER

Company Name _____

Address _____ Phone Number _____

City _____ State _____ Zip Code _____

MEDICAL INSURANCE

Primary Insurance _____ Secondary Insurance _____

ID # _____ Group # _____ ID # _____ Group #: _____

Subscriber _____ Subscriber _____

Co-Pay \$ _____ Effective Date _____ Co-Pay \$ _____ Effective Date _____

Referral Required YES NO Referral Required YES NC

Pharmacy Name / Address / Phone:

Prescription Drug ID#: _____ Rx Group# _____

Rx Bin#: _____

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 copay 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 a finance charge on any balance billed and left unpaid more than 60 days. I further understand that any amount left unpaid for more than 60 days from the first billed date 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 any collection fee. 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.

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 of visit: _____

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**

- | | | | |
|---|-----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Nasal blockage | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Itchy nose |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Headache | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Other: |

When are you symptomatic: Winter Spring Summer Fall

Medications taken and their effects:

_____	_____
_____	_____
_____	_____

Suspected or known causes of these symptoms:

- | | | | |
|--------------------------------|--------------------------------|--|---------------------------------|
| <input type="checkbox"/> Colds | <input type="checkbox"/> Weeds | <input type="checkbox"/> Dust | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Trees | <input type="checkbox"/> Cats | <input type="checkbox"/> Mold | <input type="checkbox"/> Foods: |
| <input type="checkbox"/> Grass | <input type="checkbox"/> Dogs | <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> 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
 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

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

Are there any **FOODS** that you are currently **AVOIDING**? NONE

Describe **PROBLEMS WITH MEDICATIONS**: NONE

Family History:

	AGE	ASTHMA	HAYFEVER	SKIN ALLERGY	OTHER
FATHER	<hr/>				
MOTHER	<hr/>				
BROTHERS	<hr/>				
SISTERS	<hr/>				
CHILDREN	<hr/>				

Environmental History:

List ALL ANIMALS in or around the home:

Note ALL SMOKERS who live in the home:

Number of packs per day_____

Number of years that you have smoked_____

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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