

ADVANCED ALLERGY & ASTHMA CARE

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Allergy, Asthma and Clinical Immunology

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Date: _____ Time: _____

This office is dedicated to providing the best quality allergy care. Your understanding of our office policies and practices will help us to help you.

Our Staff

Doctors, Bell, Lee, Shah and Dave are Board Certified Allergists. They have completed approved specialty training in Allergy and Clinical Immunology, and have passed a certifying examination by the American Board of Allergy and Immunology. All of our nurses have experience in general nursing as well as special training in allergy. Our medical receptionists and our insurance specialists are knowledgeable in their fields and eager to help. We are all interested in making your treatment as pleasant and effective as possible.

Office Hours

All visits are by appointment only. Although our schedule may vary according to changing circumstances, in general the Danbury office is open Mondays, 8:00-6:30; Tuesdays, 8:00-4:30; Wednesdays, 7:30-4:30; Thursdays, 9:00-6:30; and Fridays, 8:30-4:00. The Ridgefield office is open Tuesdays, 8:30-5:00, and Thursdays, 8:00-5:00.

Appointments and Policies

- We respect your time and make every effort to minimize waiting time by scheduling appointments carefully. Please assist us by arriving **15 minutes prior** to your appointment in order to allow the receptionist and nurse to complete their tasks before your scheduled time with the doctor. Your understanding is appreciated on those occasions when circumstances cause a delay in our schedule.
- **If your appointment needs to be rescheduled or cancelled, please notify the office at least 24 hours in advance. Patients not demonstrating this consideration will be charged \$30 for each missed appointment and may not be allowed to reschedule appointments in the future.**
- Cell phone conversations are disturbing to others. Please **turn off your cell phone** while in our office.
- Parents are responsible for the behavior of their children in this office. Please supervise your child's quiet play.
- **FOR THE SAFETY OF OUR PATIENTS WITH FOOD ALLERGIES, PLEASE DO NOT BRING FOOD OR BEVERAGES (OTHER THAN WATER) INTO THE OFFICE.**

Insurance and Payments

Our office participates with many – but not all – managed care insurance plans. We also accept Medicare assignment. For plans with which we participate, your obligation is to pay any applicable deductible and/or co-payment at the time of your visit.

It is your responsibility to obtain any referrals or pre-authorizations required by your plan. Please note that our checking that a referral has been made and that benefits have been “verified” does not assure that your policy is in force. If the policy is not in force, you are responsible for the charges.

If you are enrolled in an insurance plan with which we do not participate, fees are your responsibility and payment is due at the time of your visit. In such cases, our office has a financial relationship with you, not your insurer, and any insurance reimbursement will be made from your insurance company directly to you.

We accept cash, check or MasterCard/Visa/Discover as method of payment. Please let us know if a financial hardship exists.

Emergency Coverage

Doctor Bell, Lee, Shah, or Dave can be reached through the answering service for evening or weekend allergy emergencies. If they are not available, another Board Certified allergist is almost always on call for coverage. Please note that on a very few occasions Doctors Bell, Lee, Shah, and Dave, and the backup allergists may be unavailable and will recommend a pediatrician or internist to the answering service.

Please note that **routine prescription refills will not be given after regular office hours.** Please check your supplies and obtain refills before you run out. Telephone refills will not be given to patients who are overdue for follow-up appointments.

Confidentiality

Your medical records are strictly private. No information regarding your condition will be given to employers, friends, relatives, insurance companies or other physicians without your consent.

Doctor-Patient Relations

A relationship of mutual respect and understanding must exist among physician, staff and patient. We make a special effort to explain fully all aspects of your condition and treatment. Please ask for further information if any aspect is not clear to you or if you have any questions.

Likewise, if you have any suggestions or complaints regarding our services or fees, please tell us.

In Conclusion

It is our sincere desire to provide you with the best medical care possible. We hope this information will help you to understand how our office functions, and we trust that our relationship will be a pleasant and productive one.

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PATIENT REGISTRATION

If The Patient Is A Child, Fill Out The Information As It Pertains To The Child

Patient First Name _____ Last Name _____ M.I. _____
(As on Insurance card)

Male Female Date of Birth ___/___/___ Age ___ Student Status: F/T P/T N/A

Social Security # _____

Street _____ City _____ State _____ Zip _____

Home Tel. # (____) _____ Business Tel. # (____) _____ Your Cell # _____

If you are interested in receiving discounts and promotional announcements from Advanced Specialty Care, please provide email address and sign consent below. To opt out at anytime, call 203-791-9661

EMAIL ADDRESS: _____

Responsible Parent/Guardian _____ Parent/Guardian Date of Birth ___/___/___

Parent/ Guardian Phone _____

Street _____ City _____ State _____ Zip _____ DOB _____

Emergency Contact Name: _____ Relationship _____

Home Tel #: _____ Cell # _____

Primary Doctor _____ Location (City) _____
(As listed on your Insurance card)

Referring Doctor _____

If your insurance plan requires an insurance authorization referral to this office, you must have this referral at the time of your visit, or full payment will be expected. It is your responsibility to ensure your authorization referral is current and on file in this office prior to seeing the physician for all visits, including follow-ups.

There are NO exceptions to the office referral policy.

*HSA POLICY-if you have a health savings account insurance plan, and your deductible has not been met, we request payment at time of service, a payment plan can be set up with our billing department. Your office visit can range anywhere from \$150-\$260, to additional testing ranging from \$200-\$800.

PRIMARY INSURANCE COMPANY INFORMATION

Information must be filled in completely, even if we copy your insurance card.

Ins. Co. Name _____ Plan _____

ID# _____ Group name or Number _____

Policy Holder's Name _____ Relation to patient _____

Sex: Male Female Date of Birth ___/___/___ Social Security # _____

Employer _____ Phone # _____

SECONDARY INSURANCE COMPANY INFORMATION

Ins. Co. Name _____ Plan _____

ID# _____ Group name or Number _____

Policy Holder's Name _____ Relation to patient _____

Sex: Male Female Date of Birth ___/___/___ Social Security # _____

Employer _____ Phone # _____

Date _____

ADVANCED ALLERGY & ASTHMA CARE

Name: _____ D.O.B: _____ Date: _____

Referring Doctor: _____ Primary Care Doctor: _____

What chief problem(s) bring you to the allergist at this time? (check all that apply)

- | | | |
|---------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Nose allergy | <input type="checkbox"/> Hives | <input type="checkbox"/> Food allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Swelling | <input type="checkbox"/> Drug allergy |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Cough | <input type="checkbox"/> Insect sting allergy |

Please list all medications currently in use or that you use as needed, including herbal medication and dosage.

<u>NAME</u>	<u>DOSE</u>

ALLERGY HISTORY

	None	To what?	When?	Reaction
Any known food allergies?				
Any known drug/medication allergies?				
Insect sting allergy?				
Any other known allergies?				

Are you allergic to latex? (Please circle) Y N

Pharmacy for refills and faxing: _____

Symptoms:

Patient Name _____ Date _____

Name of other family members who are patients of Advanced Allergy and Asthma Care _____

If your problem is with the **nose, ears or eyes**, does it include:

- | | | | |
|------------------------|-----------------|--|---------------------|
| sneezing | loss of smell | sinus infections needing antibiotic (____per year) | |
| watery nasal discharge | mouth breathing | ear infections needing antibiotic (____per year) | |
| discolored discharge | snoring | loss of hearing | redness of eyes |
| post-nasal drip | sinus pressure | itching of ears | itching of eyes |
| nasal itch | nose bleeds | _____ | swelling of eyelids |
| nasal blockage | headache | _____ | tearing ? |

If your problem is with the **chest**, does it include:

- | | | |
|-----------------------|--|--|
| coughing | shortness of breath | decreased exercise capacity |
| wheezing you can hear | awakening at night | asthma attack(s) requiring emergency treatment |
| wheezing heard by MD | chest pain | asthma attack(s) requiring overnight hospitalization |
| tightness in chest | repeated episodes of bronchitis needing antibiotics (____per year) ? | |

If your problem is with the **skin**, does it include:

- | | | |
|----------|---------|-----------|
| hives | eczema | redness |
| swelling | dryness | itching ? |

If your problem is related to an **insect sting**, did you experience:

- | | |
|--|---|
| swelling at the site of the sting only | loss of consciousness |
| hives over the entire body | wheezing |
| swelling away from the site of the sting | fullness of throat or difficulty swallowing |
| dizziness or faintness | nausea or vomiting ? |

If your problem is related to a **food or drug allergy**, did you experience:

- | | |
|-------------------------------|---|
| localized swelling only | loss of consciousness |
| hives over the entire body | wheezing |
| swelling in areas of the body | fullness of throat or difficulty swallowing |
| dizziness or faintness | nausea or vomiting ? |

What worsens symptoms: _____

Please circle any of the following that you know worsen symptoms:

- | | | | |
|-------------------------------|------------------|---------------------|-------------------|
| dust | cats | dogs | horses |
| cigarette smoke | birds | other animal: _____ | |
| chlorine or irritants | strong odors | recumbency | |
| worse at work/school | worse at home | worse at _____ | |
| seasonal: | spring | summer | winter fall |
| meals alcohol | foods: _____ | | |
| menstrual cycle | emotional stress | laughter | physical exertion |
| pollen | cut grass | mold | |
| change in barometric pressure | cold air | wind | morning night |

GENERAL HEALTH: (ROS) (Please check any of the symptoms you have)

Patients Name _____ Date _____

- | | | | |
|---|---|--|---|
| General (constitutional)
<input type="checkbox"/> fever
<input type="checkbox"/> chills/night sweats
<input type="checkbox"/> fatigue
Head
<input type="checkbox"/> headache
<input type="checkbox"/> sinus pain
Eyes
<input type="checkbox"/> poor vision
<input type="checkbox"/> eye pain
<input type="checkbox"/> dry eyes
<input type="checkbox"/> itchy eyes
<input type="checkbox"/> red eyes
Ears
<input type="checkbox"/> hearing loss
<input type="checkbox"/> discharge from ears
<input type="checkbox"/> ringing in ears
Throat
<input type="checkbox"/> sore throat/pain
<input type="checkbox"/> tightness in throat
<input type="checkbox"/> choking
<input type="checkbox"/> clearing throat

Nose
<input type="checkbox"/> discharge
<input type="checkbox"/> bleeding
<input type="checkbox"/> sneezing
<input type="checkbox"/> itching
<input type="checkbox"/> dryness
<input type="checkbox"/> congestion | Lungs (respiratory)
<input type="checkbox"/> shortness of breath
<input type="checkbox"/> cough
<input type="checkbox"/> wheeze
<input type="checkbox"/> congestion

Cardiovascular
<input type="checkbox"/> chest pain
<input type="checkbox"/> palpitations
GI
<input type="checkbox"/> gagging
<input type="checkbox"/> heartburn
<input type="checkbox"/> nausea/vomiting
<input type="checkbox"/> difficulty swallowing
<input type="checkbox"/> abdominal pain
<input type="checkbox"/> diarrhea
<input type="checkbox"/> constipation

Urinary
<input type="checkbox"/> difficulty urinating
<input type="checkbox"/> blood in urine | Joints (musculoskeletal)
<input type="checkbox"/> joint swelling
<input type="checkbox"/> joint pain
<input type="checkbox"/> muscle aches

Psychological/Nerves
<input type="checkbox"/> depression
<input type="checkbox"/> anxiety
<input type="checkbox"/> emotional disturbance
<input type="checkbox"/> vertigo
<input type="checkbox"/> fainting
<input type="checkbox"/> loss of smell
<input type="checkbox"/> convulsions

Dermatologic
<input type="checkbox"/> dry skin
<input type="checkbox"/> itchy skin
<input type="checkbox"/> change in color of skin
<input type="checkbox"/> skin rash
<input type="checkbox"/> eczema
<input type="checkbox"/> hives
<input type="checkbox"/> swelling | Hematologic
<input type="checkbox"/> easy bruising
<input type="checkbox"/> easy bleeding

Metabolic
<input type="checkbox"/> increased thirst
<input type="checkbox"/> temperature intolerance (cold or hot)?
<input type="checkbox"/> cold hands/feet
<input type="checkbox"/> increased urination
<input type="checkbox"/> excessive sweating |
|---|---|--|---|

HAVE YOU HAD ANY OF THE FOLLOWING?

- CT Scan Yes No When: _____ Where: _____
- MRI Yes No When: _____ Where: _____
- Ultrasound Yes No When: _____ Where: _____
- X-Ray Yes No When: _____ Where: _____
- Pulmonary Function Test Yes No When: _____ Where: _____
- Allergy Testing Yes No When: _____ Where: _____
- Allergy shots Yes No When: _____ Where: _____
- Blood Work Yes No When: _____ Where: _____

PAST MEDICAL HISTORY

- | | |
|---|---|
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Type: _____
Other _____
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____
Depression <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

IN THE PAST TWO YEARS HAVE YOU TAKEN ANTIBIOTICS FOR:

- | | |
|---|-----------------------|
| <input type="checkbox"/> Throat infection | How many times: _____ |
| <input type="checkbox"/> Ear infection | How many times: _____ |
| <input type="checkbox"/> Bronchitis/Pneumonia | How many times: _____ |
| <input type="checkbox"/> Sinus infection | How many times: _____ |

SURGICAL HISTORY: List hospitalizations and date

- Tonsillectomy When: _____
- Adenoidectomy When: _____
- Ear tubes When: _____
- Nasal polyp surgery When: _____
- Nasal or sinus surgery When: _____
- Other When: _____

Family History

Patient Name _____ Date _____

Is there a family history of:

- | | | | | | | | | |
|---------------|---------------------------|--------------------------|--------------------|---------------------------|--------------------------|---------------------|---------------------------|--------------------------|
| Allergies | <input type="radio"/> Yes | <input type="radio"/> No | Stroke | <input type="radio"/> Yes | <input type="radio"/> No | Mental illness | <input type="radio"/> Yes | <input type="radio"/> No |
| Alzheimers | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes | <input type="radio"/> Yes | <input type="radio"/> No | Migraines | <input type="radio"/> Yes | <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes | <input type="radio"/> No | Breast Cancer | <input type="radio"/> Yes | <input type="radio"/> No | Renal disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Alcoholism | <input type="radio"/> Yes | <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes | <input type="radio"/> No | Seizure disorder | <input type="radio"/> Yes | <input type="radio"/> No |
| Blood disease | <input type="radio"/> Yes | <input type="radio"/> No | Hearing deficiency | <input type="radio"/> Yes | <input type="radio"/> No | Anesthesia Reaction | <input type="radio"/> Yes | <input type="radio"/> No |
| Heart disease | <input type="radio"/> Yes | <input type="radio"/> No | Hyperlipidemia | <input type="radio"/> Yes | <input type="radio"/> No | Blood clots | <input type="radio"/> Yes | <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes | <input type="radio"/> No | Hypertension | <input type="radio"/> Yes | <input type="radio"/> No | | | |

Is there a family history of any of the following Allergy medical problems?

	PARENTS	CHILDREN	SIBLINGS	OTHER FAMILY MEMBERS
ALLERGIC RHINITIS				
HAY FEVER				
ASTHMA				
ECZEMA				
FOOD ALLERGY				
DRUG ALLERGY				
INSECT ALLERGY				
AUTO IMMUNE DISEASE				

Social History: _____ For child: N/A

TOBACCO

Currently Smoke? Yes No

Smoked in the past How much? _____

ALCOHOL: Do not drink Drink socially Drink daily

Caffeine: None Cups _____

If patient is a child

Child lives with: Mother Father Other

Mothers full name _____ Fathers full name _____

Day care out of house? Yes No

Household smoke exposure? Yes No

Environmental:

Heating: forced hot air hot water radiat/baseboard gas electric

Devices: dehumidifier air cleaner wood/pellet stove

Air conditioner? Y N

Bedroom Carpeting: None wall to wall area rugs

Residence: private home apartment basement other _____

Irritant Exposures: secondhand smoke fumes other _____

Animal Exposure: Do you have pets? Y N

What and how many? _____

Do they come in bedroom? Y N Do they come in bed? Y N

Occupation: _____

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Antihistamines and certain other medications interfere with the accuracy of allergy skin testing. The following is a list of common antihistamines. In addition, many **cold/sinus preparations** and **eye drops** contain antihistamines. Some **herbs, plants and supplements** (including naturopathic/homeopathic) may also decrease the accuracy of allergy skin testing, and therefore all such products should be withheld for one week prior to testing

Samples of Antihistamines

Do not take for this number of days before the test date:

Clarinet	6 days
Claritin/Claritin-D, Alavert (Loratadine)	4 days
Allegra (Fexofenadine)	3 days
Most older antihistamines:	2 days
Benadryl (Diphenhydramine), Actifed, Allerest, Nyquil, Chlor-Trimeton, Triaminic, Dimetapp, Drixoral, Tavist, etc. and medications ending in "PM"	
Thera-flu (Pheniramine)	2 days
Periactin (Cyproheptadine)	3 days
Zyrtec (Cetirizine)	5 days
Xyzal	5 days
Atarax (Hydroxyzine)	5 days
Astelin Nasal Spray (Azelastine), Astepro	4 days
Patanase	3 days
Tricyclic Antidepressants:	*5 days
*Elavil (Amitriptyline)	
*Pamelor ((Nortriptyline)	
*Tofranil (Imipramine)	
*Sinequan (Doxepin)	
*Desipramine	
Meclizine (Antivert, Bonine, Dramamine)	3 days
*Remeron (Mirtazapine)	*7 days
*Abilify (Aripiprazole)	*5 days
*Seroquel (Quetiapine)	*2 days
Midol	2 days
Topical Doxepin cream	12 days
Optivar and Elestat Ophthalmic Solution	3 days
All other allergy eye drops	2 days

***IMPORTANT:** Do not stop any medication with a * without consulting the prescribing physician.

IF you are experiencing hives or other allergy symptoms that will make you uncomfortable when antihistamines are withheld, **DO NOT STOP** your medication prior to the Doctor's office visit.

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:

**Notice of Privacy Practices
Informed Consent
Practice Financial Policies
ADVANCED SPECIALTY CARE**

107 Newtown Road, Danbury, CT 06810
146 Danbury Road New Milford, CT 06776

901 Ethan Allen Highway, Ridgefield, CT 06877
22 Old Waterbury Road, Southbury, CT 06488

Privacy Officer: Jennifer Retter, Business Manager (203) 830-4700 ext. 265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the person(s) listed below to discuss my medical information. **If you do not speak English please list the name and phone number of who we can call to discuss your medical information with.**

Name & phone number

Relationship to Patient

Name & phone number

Relationship to Patient

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, or other diagnostic test results from outside facilities. At times these facilities may require an authorization to release such records. My signature authorizes the release of any diagnostic test results that we may require in order to provide treatment.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

If this office does not have a contract with my insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited.

Signature (Parent or Guardian if Patient a Minor)

Relationship To Patient

Please Print Name

_____/_____/_____
Date

Patients Name (if Minor)

_____/_____/_____
Patient's date of birth