

## ADVANCED ALLERGY & ASTHMA CARE

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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 Baum 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, Thursdays, 8:00-5:00, Friday, 9:00-12:00, (summer hours may vary.)

### 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 Baum 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 Baum 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.

\\ASCEPMAUsers\Public\FORMS\Allergy Current\New patient Letter02\09.doc

# 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>

<b>ALLERGY HISTORY</b>	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: \_\_\_\_\_

**NEW 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 your email address and sign consent below. If you would like to opt out at anytime, you can call 203-791-9661

EMAIL ADDRESS: \_\_\_\_\_

Responsible Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_ DOB \_\_\_\_\_

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.

**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 # \_\_\_\_\_

If this office does not have a contract with your insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. It is your responsibility to follow up on any outstanding claims sent to your insurance company, and to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. If services rendered are considered non-covered by your insurance company you will be responsible for payment in full.

This signature on file indicates that I have read and agree to the terms above. It is also an authorization to release my medical records, which may include photographs, to the physicians listed above and those physicians who may be involved in my care now and in the future, as well as information necessary to process my claims. I hereby authorize payment directly to the physician named of the insurance benefits otherwise payable to me. I authorize the care and treatment provided to me under the general or specific directions of my physician or physician assistant.

\_\_\_\_\_  
Patient Signature (If Minor, Parent/Guardian Signature)

\_\_\_\_\_  
Parent/Guardian Date of Birth

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**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:

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

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> coughing              | <input type="checkbox"/> shortness of bre   | <input type="checkbox"/> decreased exercise capacity                          |
| <input type="checkbox"/> wheezing you can hear | <input type="checkbox"/> awakening at ni;   | <input type="checkbox"/> asthma attack(s) requiring emergency treatment       |
| <input type="checkbox"/> wheezing heard by MD  | <input type="checkbox"/> chest pain   | <input type="checkbox"/> asthma attack(s) requiring overnight hospitalization |
| <input type="checkbox"/> tightness in chest    | <input type="checkbox"/> repeated episodes of bronchitis needing antibiotics (____per year) ? |   |

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

- |                                   |                                  |                                    |
|-----------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> hives    | <input type="checkbox"/> eczema  | <input type="checkbox"/> redness   |
| <input type="checkbox"/> swelling | <input type="checkbox"/> dryness | <input type="checkbox"/> itching ? |

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

- |   |  |
|---|--|
| <input type="checkbox"/> swelling at the site of the sting only | <input type="checkbox"/> loss of consciousness                       |
| <input type="checkbox"/> hives over the entire body             | <input type="checkbox"/> wheezing                                    |
| <input type="checkbox"/> swelling away from the site of th      | <input type="checkbox"/> fullness of throat or difficulty swallowing |
| <input type="checkbox"/> dizziness or faintness                 | <input type="checkbox"/> nausea or vomiting ?                        |

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

- |  |  |
|--|--|
| <input type="checkbox"/> localized swelling only       | <input type="checkbox"/> loss of consciousness                       |
| <input type="checkbox"/> hives over the entire body    | <input type="checkbox"/> wheezing                                    |
| <input type="checkbox"/> swelling in areas of the body | <input type="checkbox"/> fullness of throat or difficulty swallowing |
| <input type="checkbox"/> dizziness or faintness        | <input type="checkbox"/> 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 \_\_\_\_\_

- |   |   |  |   |
|---|---|--|---|
| <b>General (constitutional)</b><br><input type="checkbox"/> fever<br><input type="checkbox"/> chills/night sweats<br><input type="checkbox"/> fatigue<br><b>Head</b><br><input type="checkbox"/> headache<br><input type="checkbox"/> sinus pain<br><b>Eyes</b><br><input type="checkbox"/> poor vision<br><input type="checkbox"/> eye pain<br><input type="checkbox"/> dry eyes<br><input type="checkbox"/> itchy eyes<br><input type="checkbox"/> red eyes<br><b>Ears</b><br><input type="checkbox"/> hearing loss<br><input type="checkbox"/> discharge from ears<br><input type="checkbox"/> ringing in ears<br><b>Throat</b><br><input type="checkbox"/> sore throat/pain<br><input type="checkbox"/> tightness in throat<br><input type="checkbox"/> choking<br><input type="checkbox"/> clearing throat<br><br><b>Nose</b><br><input type="checkbox"/> discharge<br><input type="checkbox"/> bleeding<br><input type="checkbox"/> sneezing<br><input type="checkbox"/> itching<br><input type="checkbox"/> dryness<br><input type="checkbox"/> congestion | <b>Lungs (respiratory)</b><br><input type="checkbox"/> shortness of breath<br><input type="checkbox"/> cough<br><input type="checkbox"/> wheeze<br><input type="checkbox"/> congestion<br><br><b>Cardiovascular</b><br><input type="checkbox"/> chest pain<br><input type="checkbox"/> palpitations<br><b>GI</b><br><input type="checkbox"/> gagging<br><input type="checkbox"/> heartburn<br><input type="checkbox"/> nausea/vomiting<br><input type="checkbox"/> difficulty swallowing<br><input type="checkbox"/> abdominal pain<br><input type="checkbox"/> diarrhea<br><input type="checkbox"/> constipation<br><br><b>Urinary</b><br><input type="checkbox"/> difficulty urinating<br><input type="checkbox"/> blood in urine | <b>Joints (musculoskeletal)</b><br><input type="checkbox"/> joint swelling<br><input type="checkbox"/> joint pain<br><input type="checkbox"/> muscle aches<br><br><b>Psychological/Nerves</b><br><input type="checkbox"/> depression<br><input type="checkbox"/> anxiety<br><input type="checkbox"/> emotional disturbance<br><input type="checkbox"/> vertigo<br><input type="checkbox"/> fainting<br><input type="checkbox"/> loss of smell<br><input type="checkbox"/> convulsions<br><br><b>Dermatologic</b><br><input type="checkbox"/> dry skin<br><input type="checkbox"/> itchy skin<br><input type="checkbox"/> change in color of skin<br><input type="checkbox"/> skin rash<br><input type="checkbox"/> eczema<br><input type="checkbox"/> hives<br><input type="checkbox"/> swelling | <b>Hematologic</b><br><input type="checkbox"/> easy bruising<br><input type="checkbox"/> easy bleeding<br><br><b>Metabolic</b><br><input type="checkbox"/> increased thirst<br><input type="checkbox"/> temperature intolerance (cold or hot)?<br><input type="checkbox"/> cold hands/feet<br><input type="checkbox"/> increased urination<br><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="radio"/> Yes <input type="radio"/> No<br>Angina <input type="radio"/> Yes <input type="radio"/> No<br>Anxiety <input type="radio"/> Yes <input type="radio"/> No<br>Asthma <input type="radio"/> Yes <input type="radio"/> No<br>Autoimmune Disorder <input type="radio"/> Yes <input type="radio"/> No<br>Bleeding Disorder <input type="radio"/> Yes <input type="radio"/> No<br>Blood Clots <input type="radio"/> Yes <input type="radio"/> No<br>Currently Pregnant <input type="radio"/> Yes <input type="radio"/> No<br>Diabetes <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No<br>Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No<br>Trauma <input type="radio"/> Yes <input type="radio"/> No<br>Ulcers <input type="radio"/> Yes <input type="radio"/> No<br>Type: _____<br>Other _____<br>Cancer <input type="radio"/> Yes <input type="radio"/> No Type: _____<br>Depression <input type="radio"/> Yes <input type="radio"/> No<br>Emphysema <input type="radio"/> Yes <input type="radio"/> 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  
 Day care out of house?  Yes  No  
 Household smoke exposure?  Yes  No  
 Occupation: \_\_\_\_\_

**Environmental:**

- Heating:  forced hot air  hot water radial/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

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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: Benadryl (Diphenhydramine), Actifed, Allerest, Nyquil, Chlor-Trimeton, Triaminic, Dimetapp, Drixoral, Tavist, etc. and medications ending in "PM"	2 days
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: *Elavil (Amitriptyline) *Pamelor ((Nortriptyline) *Tofranil (Imipramine) *Sinequan (Doxepin) *Desipramine	*5 days
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.