

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, and Shah 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 and 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.

NAME

DOSE

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

ALLERGY HISTORY

Any known food allergies?

Any known drug/medication allergies?

Insect sting allergy?

Any other known allergies?

	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 | Lungs (respiratory)
<input type="checkbox"/> shortness of breath
<input type="checkbox"/> cough
<input type="checkbox"/> wheeze
<input type="checkbox"/> congestion | Joints (musculoskeletal)
<input type="checkbox"/> joint swelling
<input type="checkbox"/> joint pain
<input type="checkbox"/> muscle aches | Hematologic
<input type="checkbox"/> easy bruising
<input type="checkbox"/> easy bleeding |
| Head
<input type="checkbox"/> headache
<input type="checkbox"/> sinus pain | Cardiovascular
<input type="checkbox"/> chest pain
<input type="checkbox"/> palpitations | 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 | 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 |
| 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 | GI
<input type="checkbox"/> gagging
<input type="checkbox"/> heartburn
<input type="checkbox"/> nausea/vomiting
<input type="checkbox"/> difficulty swallowing | 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 | |
| Ears
<input type="checkbox"/> hearing loss
<input type="checkbox"/> discharge from ears
<input type="checkbox"/> ringing in ears | Urinary
<input type="checkbox"/> abdominal pain
<input type="checkbox"/> diarrhea
<input type="checkbox"/> constipation
<input type="checkbox"/> difficulty urinating
<input type="checkbox"/> blood in urine | | |
| 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 | | | |

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

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: _____

ALLERGY & ASTHMA ASSOCIATES, P.C.
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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 drop 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.

<u>Samples of Antihistamines:</u>	<u>Do not take for this number of days before the test date:</u>
Clarinet	6 days
Claritin/Claritin D, Alavert (Loratadine)	4 days
Allegra (Fexofenadine)	3 days
Most older antihistamines: Benedryl (Diphenhydramine), Chlor-Trimeton, Actified, Dimetapp, Triaminic, Nyquil, Drixoral, Allerest, Tavist, etc., and medications ending in "PM"	2 days
Thera-flu (Pheniramine)	2 days
Periactin	3 days
Zyrtec (Cetirizine)	5 days
Atarax (Hydroxyzine)	5 days
Astelin Nasal Spray (Azelastine)	4 days
Xyzal	5 days
Tricyclic Antidepressants: *Elavil (Amitriptyline) *Pamelor (Nortriptyline) *Tofranil (Imipramine) *Sinequan Doxepine *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 medications 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 doctor's office visit.