PATIENT REGISTRATION

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

Date _____

Patient First Name_____Last Name_____M.I.____
(As on insurance card)

Male ❑ Female Date of Birth ____/____/____ Age_____ Social Security # _____ ____ _____ Student Status: F/T P/T

Street_____ City_____ State_____ Zip_____

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

Primary Doctor_____ Was this your referring physician? ☐ NO ☐ YES
(As listed on your insurance card) Location (City) _____

Were you referred here by another physician? ☐ NO ☐ YES If yes, which one _____

IS TODAY'S VISIT RELATED TO AN INJURY, ACCIDENT OR 3RD PARTY PAYER? ☐ **NO** ☐ **YES**

Information needed for governmental compliance:

Race: White
African American
Asian
American Indian
Other_____
Refuse to answer

Preferred Language: English
Spanish
Refuse to answer

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Refuse to answer

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** _____
Emergency Contact Name: _____ **Relationship** _____
Home Tel #: _____ **Cell #** _____

By checking, you authorize Advanced Specialty Care to discuss your medical information with the emergency contact listed above.

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. is <u>your</u> responsibility to ensure your authorization referral is <u>current</u> and on file in this office prior to seeing the physician for all visits, including follow-ups.

There are <u>NO</u> 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 #_____

Allergy Intake

Patients Name:_____

Patients Date of Birth:_____

Today's Date:_____

Patients Height and Weight:_____

Please list all medications and dosage you are currently taking (Including prescription, non-prescription, herbal supplements)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Allergies to medication: Drug name/Reaction

_____ _____

_____ _____

_____ _____

Latex Allergy ☐ Yes ☐ No

If yes please describe:

Review of symptoms: Please circle Yes or No

Abnormal bleeding	Y/N	Heartburn	Y/N
Anxiety	Y/N	Heart murmur	Y/N
Blood in urine	Y/N	Itchy eyes	Y/N
Clearing Throat	Y/N	Joint swelling	Y/N
Cough	Y/N	Nasal congestion	Y/N
Depression	Y/N	Rash	Y/N
Discharge from ears	Y/N	Temperature	Y/N
Easy bruising	Y/N	Intolerance	
Fever	Y/N	Visual changes	Y/N
Headache	Y/N		

Please answer if you are over the age of 50 (otherwise disregard)

Have you had any influenza (flu) vaccine this season (Sept.-Feb. ☐ Yes ☐ No

Please answer if you are over the age of 65(otherwise Disregard)

Have you ever had the pneumococcal vaccine? ☐ Yes No ☐

Pharmacy Information

Name:_____

Location:_____

Referring MD:_____

Primary Care MD:_____

Surgical History

Tonsillectomy	☐ Yes	☐ No	When _____
Adenoidectomy	☐ Yes	☐ No	When_____
Ear tubes	☐ Yes	☐ No	When_____
Nasal polyp surgery	☐ Yes	☐ No	When_____
Nasal or sinus surgery	☐ Yes	☐ No	When_____
Other_____	☐ Yes	☐ No	When_____

When is the last time you had?

Chest X-ray_____ Facility_____

Lung test _____ Facility _____

Sinus CT scan_____Facility_____

Allergy testing_____ Facility_____

Allergy shots_____ Facility_____

Personal Medical History: Please circle Yes or No

Anemia	Y/N	Heart Disease	Y/N
Anxiety	Y/N	High Blood Pressure	Y/N
Asthma	Y/N	Kidney Disorder	Y/N
Autoimmune Disorder	Y/N	Liver Disease	Y/N
Bleeding Disorder	Y/N	Pacemaker	Y/N
Blood clots	Y/N	Psychiatric Illness	Y/N
Cancer: Type_____	Y/N	Reflux	Y/N
Cataracts	Y/N	Sleep Apnea	Y/N
Currently Pregnant	Y/N	Seizure disorder	Y/N
Diabetes	Y/N	Thyroid Disorder	Y/N
Emphysema	Y/N		

List any other pertinent medical history:

1. _____

2._____

3. _____

Family History: Please circle Yes or No

Allergic Rhinitis	Y/N	Diabetes	Y/N
Anesthesia Problems	Y/N	Drug Allergy	Y/N
Asthma	Y/N	Eczema	Y/N
Autoimmune Disorder	Y/N	Food allergy	Y/N
Bleeding disorder	Y/N	Hay fever	Y/N
Cancer	Y/N	Heart Disease	Y/N
		Insect Allergy	Y/N

List any other pertinent family history:

1. _____
2. _____
3._____

Social History: (Smoking status for patients 13 yrs. and older)

Occupation:_____

Current every day smoker ☐

Current occasional smoker ☐

Smoker, current status unknown ☐

Never smoker ☐

Former smoker ☐

Unknown if ever smoked ☐

If yes, type: (Please choose)

☐ Chewing ☐ Cigarettes ☐Cigar ☐Smokeless ☐ Snuff ☐ Pipe

Alcohol: ___Do not drink ___Drink socially ___Drink daily

Do you consume caffeine Y/N

If patient is child:

Child lives with: ___Mother ___Father ____Other

Mother's full name_____

Father's full name _____

Day care? ☐ Yes ☐ No

Exposed to smokers? ☐ Yes ☐ No

Environment at home:

Mattress: Please choose one:

Type: ☐ Latex ☐ Foam ☐ Innerspring ☐ Other

Dust mite proof covers (mattress or pillows)? ☐ Yes ☐ No

Devices (Choose any in the home)

Dehumidifier ☐

Air purifier ☐

Wood/pellet stove ☐

Air conditioner ☐ Yes ☐ No

Carpeting (choose one) ☐None ☐ Wall to wall ☐ Area rugs

Residence

Private Home ☐

Apartment ☐

Basement? ☐ Yes ☐ No

Do you have any pets? (Choose all that apply)

☐ Cats ☐ Dogs ☐ Birds ☐ Other

Have you seen cockroaches or ladybugs in the home?

☐ Yes ☐ No

Is there visible mold in the home? ☐ Yes ☐ No

List family members that are patients here:

_____ _____

_____ _____

_____ _____

_____ _____

Advanced Allergy & Asthma Care

Name_____ D.O.B_____ Date_____

Please circle the reason(s) for your visit today:

Nose symptoms	Hives or Swelling	Food Allergy
Asthma	Cough	Drug allergy
Eczema	Insect Sting Allergy	Other

There are many sections below, please fill out the sections for which you have symptoms:

IF YOU HAVE ASTHMA SYMPTOMS:

Have you been diagnosed with Asthma? Yes No

If so, at what age? _____

Have you had any hospitalizations or ER visits for asthma? Yes / No. If yes, list approximate dates:

_____

Have you been treated with oral steroid pills/liquid (eg: prednisone, medrol, prednisolone) for asthma? Yes / No

How many courses of steroids in the past one year? _____

Have you ever been prescribed any of the following inhalers? (Please circle)

Advair / Symbicort / Dulera / Flovent / Asmanex / QVAR / Pulmicort / Alvesco/Other_____

What symptoms of asthma do you experience? cough / wheeze / shortness of breath / chest tightness

How many days per week do you experience these symptoms? _____

How many days per week do you use a rescue inhaler (albuterol/xopenex)? _____

How many nights per month does your asthma hinder your ability to sleep? _____

Does your asthma interfere with your ability to do activities you would like to do? Yes/No

What triggers your asthma? (Please circle) exercise / cold / heat / respiratory infections / change of seasons / pollens / animals / dust / mold / strong smells (such as tobacco, perfumes, detergents, etc.)

IF YOU HAVE NASAL/EYE/EAR ALLERGY SYMPTOMS

Circle the following symptoms that affect you:

sneezing / runny nose / stuffy nose / post nasal drip / itchy nose / itchy eyes / watery eyes / puffy eyes / itchy ears / itchy throat / headache / sinus pressure / snoring

What is your worst symptom of the above? _____

What make these symptoms worse? indoors / outdoors / strong smells (such as perfumes and cleaning detergents) / cats / dogs / dust / molds / feathers or birds/spring/summer/fall/winter

What is your strongest trigger? _____

What medications have you tried for these symptoms?

_____ _____

_____ _____

IF YOU HAVE SINUS SYMPTOMS :

Do you struggle with frequent sinus infections? Yes / No. If yes, how many in a given year?

_____

Have you ever had nasal polyps? Yes / No. Have you lost your sense of smell or taste? Yes / No.

Have you ever had sinus surgery? Yes / No. If yes, list dates: _____

IF YOU HAVE HIVES:

Have you ever had hives before in your lifetime? Yes / No

When did current episode of hives start? _____

How many days per week do you have hives?_____

Typically how long do individual hives last? _____

Are the hives intensely itchy? Yes / No

When hives are gone do they leave a mark on your skin? Yes / No

Have you had any infections/illnesses in the 10 days prior to the onset of hives? Yes/No

Please list any triggers you are concerned about

_____ _____ _____

_____ _____ _____

Do you take any aspirin, ibuprofen or ibuprofen-like (advil, aleve, naproxyn, etc) medications? Yes / No

If yes, list: _____

Have you noticed the hives to be worse with the following? Heat / cold / exercise / scratching / stress / showers / menses / alcohol / pressure on the skin (such as waist band and bra strap areas)

Have you had swelling? Yes / No. If so, where?

_____

Have you had any of the following? (Please circle) throat closing / shortness of breath / change in your voice / tongue swelling / a sensation of something stuck in your throat

Do you have an epi pen? Yes / No

OTHER ALLERGIC HISTORY:

Do you have any food allergies? Yes / No If yes, list each food and the reaction you had to it:

_____

_____

_____

_____

Have you had any problems after bee or wasp stings? Yes / No If yes, describe the reaction (Do not include reactions to mosquito bites):

_____

_____

Do you have any drug allergies? Yes / No If yes, list each medication and describe the reaction:

_____

_____

Do you have a history of latex allergy? Yes / No. If yes, describe the reaction

Do you have a history of eczema? Yes / No

ADVANCED ALLERGY & ASTHMA CARE
Jonathan B. Bell, M.D.
Richard J. Lee, M.D.
Purvi P. Shah, M.D.
Yogen Dave, M.D.
Sara I. Dever, M.D.
Allergy, Asthma and Clinical Immunology

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(203) 403-7315
Fax (203) 730-4164

488 Main Ave, 2nd Floor
Norwalk, CT 06851
(203) 857-9216
Fax (203) 857-8681

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**. Please note, our schedules vary according to location.

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 $25-$50 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 - 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, Dave, or Dever 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, Dave, and Dever 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.

Advanced Allergy & Asthma Care
Jonathan Bell, MD, Richard Lee, MD
Purvi Shah, MD, Yogen Dave, MD, Sara Dever, MD

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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

Examples of Antihistamines	**Do not take for this number of days before the test date:**
Zyrtec (Cetirizine)	5 days
Xyzal (Levocetirizine)	5 days
Clarinex (Desloratidine)	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.	2 days
Medications ending in "PM" (such as Tylenol PM, Advil PM, Motrin PM)	2 days
Thera-flu (Pheniramine), Ny-quil	2 days
Periactin (Cyproheptadine)	3 days
Atarax (Hydroxyzine)	5 days
Astelin Nasal Spray (Azelastine), Astepro, Dymista	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)	*6 days
Midol	2 days
Topical Doxepin cream	12 days
Optivar and Elestat Ophthalmic Solution	3 days
All other allergy eye drops (Patanol, Pataday, Bepreve, Opcon A, Naphcon-A, Zaditor)	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
131 Kent Road New Milford, CT 06776

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

Privacy Officer: Jennifer Retter, Privacy Officer (203) 830-4700 ext. 8265

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**

_____
_____
Emergency Contact 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.

I understand that I will be charged a $25-$50 **NO-SHOW** fee if I do not show up at my scheduled appointment. In order to avoid the **NO-SHOW** fee an appointment needs to be cancelled 24 hours prior.

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 please sign if Patient a Minor)** **Relationship to Patient**

_____ _____/_____/_____
Please Print Name **Date**

_____ _____ / _____ / _____
Patients Name (if Minor) **Patient's date of birth**