ALLERGY & ASTHMA ASSOCIATES

Neil Feldman, D.O.
Rebecca Aul, C.R.N.P.

This is to confirm your appointment on:

Location:

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TO PROCESS THE PAPERWORK - **BRING ALL INSURANCE CARDS**

1. Your visit will take approximately 2 hours.
2. **Do not take medications containing antihistamines for 72 hours prior to your scheduled visit**. If you are not sure of the ingredients of your medications, please call our office.
3. Bring a list of medications you have been taking.
4. **BRING ANY INHALERS YOU ARE CURRENTLY USING.**
5. Wear clothing with short sleeves. Avoid wearing fragrances & body lotions.

****No food or beverages are allowed in the exam room****

6. Complete the enclosed forms and present them to the receptionist. **We will need to copy your insurance card and drivers license.**
7. If you are unable to keep this appointment, please cancel at least one day in advance. If we are not notified of a cancellation, we must bill you for the visit.

CO-PAYS MUST BE PAID AT TIME OF SERVICE

ANYONE ARRIVING 15 MINUTES OR MORE PAST THE APPOINTMENT TIME MAY BE ASKED TO RESCHEDULE

Allentown Medical Center
401 N. 17th St, Ste 211, Allentown, PA 18104 610-437-0711 Fax 610-437-9265

Free parking is available in the lot behind the building. Enter the parking lot from 16th and Gordon Streets. An attendant in the booth may ask you which doctor you are seeing.

Patient: _____ Date: _____
Last First MI

Address: _____
Street City State Zip

Phone: Home _____ Work _____ Cell _____ Email _____

Birthdate: _____ Age: ____ Sex: ____ Social Security #_____

Marital Status: M S D W Maiden Name: _____

Race: _____ Primary Language Spoken: _____

Employer: _____ Phone: _____

Spouse: _____ Birthdate: _____Social Security#_____

Employer: _____ Phone: _____

COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE

Responsible person: _____ Relationship: _____

Address: _____

Phone: (H)_____ (W) _____ (C) _____

Birthdate: _____ Age: ____ Sex: _____Social Security# _____

Employer: _____ Phone: _____

Primary Insurance Subscriber - Name: _____**DOB:** _____

Address: _____
Street City State Zip

Phone: (H) _____ (W) _____ (C) _____

Emergency Contact _____ Relationship _____

Phone: (H) _____ (W) _____ (C) _____

Referred by: Dr. _____

☐ family ☐ friend ☐ Yellow Pages ☐ other

Name of Primary Care Doctor: _____

Address: _____ Phone: _____

☐ **Pharmacy** _____ ☐ **Mail Order Pharmacy** _____

Have you ever tried any of the following medication?

1.	Allegra	☐yes ☐no	effective?	☐yes ☐no
2.	Fexofenadine	☐yes ☐no		☐yes ☐no
3.	Claritin	☐yes ☐no		☐yes ☐no
4.	Loratadine	☐yes ☐no		☐yes ☐no
5.	Alavert	☐yes ☐no		☐yes ☐no
6.	Clarinex	☐yes ☐no		☐yes ☐no
7.	Zyrtec	☐yes ☐no		☐yes ☐no
8.	Cetirizine	☐yes ☐no		☐yes ☐no
9.	Benadryl	☐yes ☐no		☐yes ☐no
10.	Xyzal	☐yes ☐no		☐yes ☐no
11.	Sudafed	☐yes ☐no		☐yes ☐no
12.	Claritin-D	☐yes ☐no		☐yes ☐no
13.	Zyrtec-D	☐yes ☐no		☐yes ☐no
14.	Flonase	☐yes ☐no		☐yes ☐no
15.	Fluticasone	☐yes ☐no		☐yes ☐no
16.	Nasalide	☐yes ☐no		☐yes ☐no
17.	Nasarel	☐yes ☐no		☐yes ☐no
18.	Flunisolide	☐yes ☐no		☐yes ☐no
19.	Nasacort AQ	☐yes ☐no		☐yes ☐no
20.	Astelin	☐yes ☐no		☐yes ☐no
21.	Astepro	☐yes ☐no		☐yes ☐no
22.	Beconase AQ	☐yes ☐no		☐yes ☐no
23.	Nasalcrom	☐yes ☐no		☐yes ☐no
24.	Nasonex	☐yes ☐no		☐yes ☐no
25.	Omnaris	☐yes ☐no		☐yes ☐no

26.	Rhinocort AQ	☐ yes	☐ no	☐ yes	☐ no
27.	Patanase	☐ yes	☐ no	☐ yes	☐ no
28.	Veramyst	☐ yes	☐ no	☐ yes	☐ no
29.	Singulair	☐ yes	☐ no	☐ yes	☐ no
30.	Pulmicort Flexhaler	☐ yes	☐ no	☐ yes	☐ no
31.	Asmanex	☐ yes	☐ no	☐ yes	☐ no
32.	QVAR	☐ yes	☐ no	☐ yes	☐ no
33.	Alvesco	☐ yes	☐ no	☐ yes	☐ no
34.	Flovent	☐ yes	☐ no	☐ yes	☐ no
35.	Advair	☐ yes	☐ no	☐ yes	☐ no
36.	Spiriva	☐ yes	☐ no	☐ yes	☐ no
37.	Symbicort	☐ yes	☐ no	☐ yes	☐ no

What is the major reason for your visit?_____ _____

Circle the symptoms you have:

NOSE: nasal congestion, post-nasal drip, frequent sneezing, runny nose, itchy nose, mouth breathing, coughing, hay fever
Is one side worse?_____ Can you smell & taste? _____

EYES: burning, itching, tearing, redness, swollen eyelids

EARS: blockage, difficulty hearing

LUNGS: frequent coughing, wheezing, shortness of breath, tightness, exercise intolerance

Circle the triggers for your symptoms:

SEASONS: spring, summer, fall, winter, year-round

WEATHER: dampness, humidity, rain, cold air

EXPOSURES: perfumes, aerosols, smoke, paint, cleaning detergents, pets, leaves, grasses, trees, basements, dust, mold, other _____

SKIN: dry, itchy, redness, hives, swelling

HEADACHES: migraine, sinus, tension
location:_____ frequency __ _____

SLEEP: snoring, fatigue in AM, fall asleep quickly, wake up frequently, dry mouth

Circle your current and past medical conditions:

GENERAL: obesity, weight gain, weight loss, fever, chills, night sweats

SKIN: hives, eczema, rash, other _____

EYES: cataracts, glaucoma, visual changes, other _____

EARS: hearing loss, ear infections, ear surgery and/or tubes, other _____

NOSE: deviated septum, sinusitis, nasal polyps, sinus/nasal surgery, other _____

NERVES: headaches, migraines, seizures, strokes, depression, anxiety, other _____

HEART: heart disease, heart attack, heart murmur, high blood pressure, surgery, pacemaker, valve problem, abnormal rhythms, other _____

LUNGS: asthma, pneumonia, emphysema, surgery, other _____

GASTROINTESTINAL: heartburn, reflux disease, stomach problems, colon, liver, esophageal problems, hepatitis, other _____

ENDOCRINE: diabetes, thyroid problems, high cholesterol, other

MALE: prostate problems, trouble urinating, other _ _____

FEMALE: pregnant, breastfeeding, trying to get pregnant, other _____

JOINTS: lupus, arthritis, muscle disease, gout, osteoporosis, other _____

BLOOD: anemia, frequent bruising, bleeding problems, immune dysfunction, other _____

INFECTIONS: frequent ear infections, sinus infections, pneumonia, bronchitis, other _____

HOSPITALIZATIONS/SURGERIES: _____ _____
_____ _____

CURRENT MEDICATIONS, herbal supplements, eye drops, OTC and prescription medications:
_____ _____
_____ _____

PAST ALLERGY HISTORY:
medication allergy:_____ none known
food allergy _____ none known
latex allergy _____ none known
insect stings: never stung, local reactions, systemic reaction, other _____

FAMILY HISTORY:

mother: alive/deceased	medical problems: asthma, allergies, other _____
father: alive/deceased	medical problems: asthma, allergies, other _____
siblings: alive/deceased	medical problems: asthma, allergies, other _____
children: alive/deceased	medical problems: asthma, allergies, other _____

SOCIAL/ENVIRONMENTAL HISTORY:
What type of home do you live in? apartment, house, mobile home, other _____

Type of heat: forced hot air, radiator, baseboard, woodstove, other _____

Type of fuel: oil, gas, electric, coal, other _____

Type of air conditioning: none, central, window. In the bedroom? yes ☐ no ☐

Type of flooring in bedroom: carpet, area rug(s), hardwood floor, tile, other _____

Do you have the following in your home?

pets: cat, dog, horse, gerbil, guinea pig, fish, rabbit, lizard, ferret, rat, mice, other: _____

are pets allowed in the bedroom? yes ☐ no ☐

basement: none, wet, dry, damp, musty

Are you exposed to secondhand smoke: yes ☐ no ☐

Explain your habits:

tobacco: current, former, never	amount: packs/day ____	# years _____
caffeine: current, former, never	amount: cups/day ____	# years _____
alcohol: current, former, never	amount: beverages/day ____	# years _____

What is your occupation: _____ _____

Exposures at work: _____

Former occupation/exposures: _____ _____

Patient/Parent/Guardian Signature: _____ Date: _____

Allergy & Asthma Associates Financial Policy

We are committed to providing you with the best possible medical care while holding down medical costs. Your clear understanding of our financial policy is important to achieve this goal.

INSURANCE: It is ***YOUR RESPONSIBILITY*** to verify that your policy is in force on your date of service and to understand the insurance carrier's coverages, rules and regulations.
All co-pays, co-insurances, deductibles and charges not covered by your insurance are your responsibility and will be billed to you by our office.

CO-PAYS MUST BE PAID AT THE TIME OF YOUR VISIT

*If you **DO NOT have insurance**, we expect payment **IN FULL*** for all treatment at the time of service unless other arrangements have been made.

If your insurance requires a **REFERRAL**, ***it is YOUR RESPONSIBILITY to obtain the REFERRAL prior to the time of service.***

Our office accepts VISA, Mastercard, Discover, checks and cash. All payments are expected at the time of service. A $25.00 charge will be assessed to accounts whose check does not clear the bank.

COLLECTIONS: Patient accounts will be ***turned over to a collection agency after 90 days*** if the balance is not paid in full or payment arrangements have not been made with the Billing Department. You will be responsible for any fees charged by the Collection Agency. Accounts turned over to collections may result in dismissal from the practice.

MISSED APPOINTMENTS: Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

RELEASE OF INFORMATION: I authorize Allergy & Asthma Associates to release any of my/my child's information and/or records to all of my insurance companies to substantiate claims and payments.

PLEASE READ AND KEEP THIS DOCUMENT

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ALLERGY & ASTHMA ASSOCIATES AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Signature of Patient/Guardian Date: _____