Dear Patient:

Welcome to Allergy & Asthma Specialists. Thank you for choosing our practice for your allergy & asthma needs. Our practice brochure is enclosed. It provides basic information about our practice and physicians. You will find our office telephone numbers and maps on the last panel of the brochure.

Please complete both sides of patient registration form as well as pages 1-3 of the allergy questionnaire. Please bring both forms with you when you come to the office. Please remember that if you or your child are having allergy testing, no antihistamines may be taken for 72 hours prior to the appointment. Consultations do not include testing.

Allergy testing appointments last from one and a half to two hours. If you know you must cancel an appointment, please call a minimum of 24 hours in advance (preferably 72 hrs.). For your convenience cancellations may be left with the answering service 24 hours a day.

If your insurance company requires a referral, please obtain the referral from your primary care physician prior to your appointment. Please be sure to bring your insurance card and co-payment each time you come to the office. We also need your driver’s license or other picture ID to scan into your medical record.

If you have additional questions, please feel free to ask the reception staff or call me directly.

We look forward to seeing you on the day of your appointment.

Sincerely yours,

(Ms.) Doreen KillKelley
Practice Manager

Please note - Appointment reminders will be left at the home telephone number you provided when you made your appointment. If you are being tested, we will also include a reminder regarding antihistamines.
Patient Name ________________________________________ Date of Birth ___________________ Age:____________________

Address_____________________________________________ City__________________________ State________ Zip__________

Phone (_____)_________________ Cell (____)_________________ Sex M F Social Security #_____________________

Occupation_____________________________________________ Marital Status____________________

Patient's Employer_____________________________________________ Phone(____)_____________________ Ext._______

Address_____________________________________________ City__________________________ State________ Zip__________

Responsible party (mother, father, guardian, self etc.)___________________________________________ DOB________________

Address (if different from patient)__________________________________________________________ City____________________State________ Zip__________

Phone (____)_________________ Social Security #______________________

| PRIMARY INSURANCE | Relationship to patient_____________________
|-------------------|------------------------------------------|
| Subscriber Name ___________________________ M F DOB______ Social Security #_____________________
| Address (if different from patient)________________________________________________________
| City__________________________ State________ Zip__________
| Subscriber's Employer__________________________________________________________ Phone(____)_____________________ Ext._______
| Employer's Address______________________________________________________________ City____________________State________ Zip__________
| Ins. Co.________________________________________________________ I.D.#_________________ Grp Name or number______________

| SECONDARY INSURANCE | Relationship to patient_____________________
|---------------------|------------------------------------------|
| Subscriber Name ___________________________ M F DOB:________ Social Security #_____________________
| Address (if different from patient)________________________________________________________
| City__________________________ State________ Zip__________
| Subscriber's Employer__________________________________________________________ Phone(____)_____________________ Ext._______
| Employer's Address______________________________________________________________ City____________________State________ Zip__________
| Ins. Co.________________________________________________________ I.D.#_________________ Grp Name or number______________

LOCAL PHARMACY ___________________________________________Addr__________________________ City________ State________

MAIL-AWAY PHARMACY_________________________________________Addr__________________________ City________ State________

Phone (____)_________________ Fax (____)__________________________

EMERGENCY CONTACT (Preferrably someone who does not live with you)

Name ___________________________ Phone(____)_________________ Relationship ______________

Address_____________________________________________ City__________________________ State________ Zip__________

YOUR PHYSICIAN (Your primary care physician or the physician who referred you to AAS)

M.D. Name_________________________________________________________ Phone(____)

Address_____________________________________________ City__________________________ State________ Zip__________
AAS FINANCIAL POLICY

We are committed to providing you with the best possible care. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- You must have your insurance card with you for each appointment.
- **Patients with insurance which we are participating/contracted with …**
  
  Copayments are due at the time of service. You should contact your insurance company to be sure of your coverage for allergy services.
- **Patients without insurance.** Payment is expected in full on the date of service.
- **Patients with insurance that requires a referral from Primary Care Physician**
  
  Referrals must be in place on the date of service. Without this referral in place, full payment or rescheduling would be required.
- We accept cash, personal checks, visa and mastercard
- **Non-Emergency treatment will be denied if:**
  
  A minor under eighteen is unaccompanied by an adult
  A patient does not have a valid health insurance card.
  A “referral” is not obtainable when required by the patient’s insurance.
  A patient has been delinquent on back payments and/or the account has been sent to our “Collection” agent.
  A patient has missed more than three previous appointments and has been advised of being denied another appointment.

I authorize the release of any medical information necessary to process this claim.

I permit a copy of this form to be used in the place of the original.

I, __________________________________________________, have read and understand the conditions for payment to Allergy & Asthma Specialists, PC as outlined above. Date: __________________________

I understand that my insurance carrier may require a referral from my Primary Care Physician as authorization for treatment. It is my responsibility to obtain this referral. If a claim is denied by my insurance carrier for failure to obtain a referral, I will be held responsible for the full balance of the claim.

Signature ___________________________ Date: __________________________

**PRIVACY POLICY** My signature below acknowledges my right to receive HIPAA policy information and I may request a copy at the time of my appointment.

Signature ___________________________ Date: __________________________
NAME: __________________________________________ | DATE: ________

Date of Birth: ________ AGE: ________ MALE FEMALE

ADDRESS: ____________________________________ | HOME PHONE: ______________________

OCCUPATION (pt or parents): _______________ | WK PHONE: ______________________

MARITAL STATUS (pt. or parents): S M W D

REFERRED BY: ______________________________ | SEND REPORT: Yes No

PLEASE LIST YOUR MAIN SYMPTOM(S) (e.g. nasal blockage, wheezing etc) Rate severity 1-10 (10 most severe)

1. ___________________________ ______
2. ___________________________ ______
3. ___________________________ ______
4. ___________________________ ______

NUMBER OF SCHOOL OR WORK DAYS MISSED IN THE PAST YEAR _____

IF YOU HAVE NASAL, SINUS OR EYE ALLERGY SYMPTOMS CIRCLE ANY OF THE FOLLOWING AND FILL OUT THIS SECTION:

Nasal congestion  Runny nose  Sneezing  Itching  Headache/Sinus pressure
Postnasal drainage  Tearing  Itching of eyes  Eye swelling

How long have you had these symptoms? ______
Do they interfere with your sleep or daily activities? ______

When are these symptoms present – circle: Spring Summer Fall Winter

Do the following worsen symptoms: perfume  smoke  cold air  a/c  ?

Have you noted green or yellow nasal secretions? ______

Have your nasal symptoms progressed? ________________

Number of sinus infections over the past year. _____

Have you had a sinus Cat scan or sinus x-ray? _______ Dates: ______

Have you had nasal polyps? ______

Do you have a sleep disorder or snoring ______?

Name the Medications that you have tried:
Pills ______________________________________________________________
Nose Sprays:_______________________________________________________
Eye drops:_________________________________________________________

IF YOU HAVE BEEN DIAGNOSED WITH ASTHMA OR HAVE CHEST PROBLEMS COMPLETE THIS SECTION:

Circle Symptoms that you experience:
Wheezing  Cough  Shortness of Breath  Chest Tightness

Do you have heartburn _____ How long have you had chest symptoms (yrs)
Have these gotten worse over time? ________________

Circle the triggers that bring out your symptoms:
Cold air  Head Colds  Pollen  Cats  Dogs  Sinus infections  Dust  Smoke
Exertion  Molds
Circle the situations that make your asthma worse:
Work  Home  School  Nighttime  Early am

How many emergency visits for asthma have you had in past 12 mo?____
How many hospitalizations for asthma?_______
Date of last chest X-ray_____________________
Number of times on prednisone?_______________
Do you have a nebulizer at home?___________
Do you have a spacer?______________

List all current asthma medications:
____________________________________________________________________________
____________________________________________________________________________

List all current physical activities:
____________________________________________________________________________
____________________________________________________________________________

ENVIRONMENTAL HISTORY
HOME/APT (_______ FLOORS)   NO YRS IN HOME _______ FLOODING_______
LIVING AREAS BELOW GRADE? _______ #SMOKERS IN HOME_______
HEAT: hot air  hot water  radiant steam  electric_________
A/C central  room  WOOD STOVE_________
HUMIDIFIER (CENTRAL/SEPARATE UNITS)_______ AIR CLEANER (CENTRAL/ROOM-HEPA
VACUUM (CENTRAL/________) OTHERS)
BEDROOM:  BOXSPRING/MATTRESS  FRAME/MATTRESS  WATERBED
PILLOW:  synthetic/feather  COMFORTER:  synthetic/feather
allergy cover:  boxspring____ mattress____ pillow____
CARPETING:  LIVING AREA_____ BASEMENT____ BEDROOM_____
PETS__________________ ARE THEY IN THE BEDROOM?________________
What kind (e.g. dog, cat)?

DO YOU HAVE A HISTORY OF
HIVES____, ECZEMA____, DRUG ALLERGIES____________________,
LATEX ALLERGY____, STINGING INSECT ALLERGY____,
FOOD ALLERGY____________________.

(Please check all applicable and explain)
____________________________________________________________________________
____________________________________________________________________________

WHEN WERE YOU LAST ALLERGY SKIN TESTED?_____________________

HAVE YOU BEEN ON ALLERGY SHOTS IN THE PAST? _______ IF YES,
START DATE _______, END DATE OR LAST SHOT________

DID THE SHOTS HELP  YES  NO  ANY SYSTEMIC REACTIONS?______________
IF HIVES OR SWELLING ARE CURRENTLY A PROBLEM COMPLETE THIS SECTION:

How frequently are these occurring?  Daily  Weekly ____________

When did these start?  ____________  How severe?  ____________

Any episodes of swelling?  Where?

What medications have been tried to control these hives?

# Times treated with prednisone?  ____________  Dates:: ____________

Circle all the triggers that bring out your hives.

What do you feel has caused your hives: ______________

Cold    Heat    Exertion    Sun Exposure    Friction    Vibration    Pressure    Bathing

Are you taking Aspirin or other anti-inflammatory medications? ______________

Do you have a history of any of the following:
Hepatitis;    thyroid problems;    lupus;    Acid reflux

IF YOU HAVE A HISTORY OF FOOD ALLERGY COMPLETE THIS SECTION:

Circle any foods that you have reacted to:
Milk    Egg    Soy    Peanuts    Tree Nuts    Wheat    Shellfish

Crustacea    Fish    (other) ______________

Are you lactose intolerant? ______

Do you have a history of swelling of the lips or mouth with thin skinned fruits? ______

What type of reaction have you had after eating these foods?

____________________________

____________________________

Do you have an Epipen? _____  Do you have eczema? _____
FAMILY HISTORY

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
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<tbody>
<tr>
<td></td>
<td>siblings</td>
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<tr>
<td></td>
<td>aunts/uncles</td>
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<tr>
<td></td>
<td>parents</td>
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<tr>
<td></td>
<td>grandchildren</td>
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</tbody>
</table>

REVIEW OF SYSTEMS:

<table>
<thead>
<tr>
<th>NFTD</th>
<th>Wt</th>
<th>Feeding</th>
<th>G &amp; D</th>
<th>Milestones</th>
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ENT: ________________________________
CNS: ________________________________
Pulmonary: __________________________
Cardiac: ____________________________
GI: ________________________________
GU: ________________________________
Skin: ________________________________
Endocrine: __________________________
Hem/Onc: ____________________________
Infectious: __________________________
Musculoskeletal/Rheum: __________________________
Psychiatric: __________________________
Constitutional symptoms: __________________________

PAST MEDICAL HISTORY

Hospitalizations: __________________________
Medical: __________________________
Surgical: __________________________
Record/Lab Review: __________________________

MEDICATION:

______________________________
______________________________
______________________________

SOCIAL HISTORY:

Smoking - Cigarette / Pipe / Cigarmount age started age stopped
Drug/Alcohol use: __________________________
Patients with insurance - our office will be happy to process your insurance claim provided referrals and correct insurance information are presented prior to service. Please take the time to look up your insurance information before your appointment to determine if you are covered for this allergy visit. Co-pays are payable on the date of service. The insurance card must be for the person being seen.

Patients without insurance – payment in full is required on the date of service. We accept MASTERCARD & VISA.

There is a $25 fee for appointments cancelled without 24 hours notice ($50 fee for “no show” appointments).

PATIENT ACCOUNTS
978-256-9528

revised 5/6/09dk
Allergy & Asthma Specialists Cancellation and Referral Policy

(Patient Copy)

CANCELLATIONS

All cancellation requests must be received in our office 48 hours prior to your visit. When you do not keep your appointment or cancel your appointment with less than 48 hours notice, you use a time slot that could have gone to another patient in need.

REFERRALS

All referrals and insurance cards must be received in our office at the time of your visit. Your options without these are as follows:

1. Reschedule your appointment
2. Sign a self referral form and pay for your visit. New patient consultations are approximately $200 and return patient visits are $100. These amounts will be refunded if a referral is obtained and payment is received from your insurance company.