ALLERGY & ASTHMA SPECIALISTS, P.C.

www.Allergy-Asthma.net

LI LIANG, M.D., PH.D.
DIPLOMATE A.B.A.I.
ANGELA AHUJA MALIK, M.D.
DIPLOMATE A.B.P.., A.B.A.I.
AMI MEHRA, M.D.
DIPLOMATE A.B.I.M., A.B.A.I.
DAVID GRUENBERG, M.D.
DIPLOMATE A.B.I.M., A.B.A.I.

Dear Patient:

Welcome to Allergy & Asthma Specialists. Thank you for choosing our practice for you 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 the **Patient Registration Form** as well as pages 1-3 of the **History & Physical 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 48 hours in advance (preferably 72 hours). For you convenience, cancellations may be left on our answering machine 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 any additional questions, please feel free to call the office.

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

Sincerely,

The Staff of Allergy & Asthma Specialists, P.C.

<u>Please Note</u> – Appointment reminders will be left at the telephone number you provided when you made your appointment. If you are being tested, we will also include a reminder regarding antihistamines.

505 WEST HOLLIS STREET ♦ SUITE 101
NASHUA, NH 03062
TEL (603) 881-7433 FAX (603) 880-3113

MAIN OFFICE
9 VILLAGE SQUARE
CHELMSFORD, MA 01824
TEL (978) 256-4531 FAX (978) 256-1377

200 SUTTON STREET ♦ SUITE 150
NORTH ANDOVER, MA 01845
TEL (978) 689-8890 FAX (978) 794-1408

ALLERGY & ASTHMA SPECIALISTS, P.C.

(Please fill out completely)

Appt. Date________________________

PATIENT REGISTRATION

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 (***Preferably someone who does not live with you***)

Name ______________________ Phone(_____)______________ Relationship ____________

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

M.D. Name______________________________ Phone(_____)______________

Address______________________ City______________ State______ Zip________

(over) please read and sign the back of this form

ALLERGY & ASTHMA SPECIALISTS, P.C.

Our priority is providing you with quality healthcare. We ask that all new patients or their guarantors present a valid insurance card and driver's license/photo identification upon check-in at each appointment.

- **Patients with insurance which we are participating/contracted with** are expected to have copayments at the time of services. You should contact your insurance company to be sure of your coverage for allergy services.
- **What if I do not have insurance or you are not a participating provider for my carrier?**
  For patients who do not carry health insurance and those for whom we do not accept their policy, payment will be expected in full at the time of the visit. Anyone who feels it is necessary to extend payments over a period of time is invited to discuss arrangements with our billing department prior to their visit.
- **What if my insurance plan requires a referral and/or prior authorization?**
  For patients' whose insurance company requires a referral and/or a prior authorization, please contact your primary care physician prior to your appointment in our offices. If your insurance company requires a referral and/or prior authorization and you do not have one – you may NOT be seen for your scheduled appointment, or you will responsible for full payment of your bill at the time of service.
- **What are my financial responsibilities as a patient?**
  As a patient, it is in your best interest to know and understand your responsibilities for **any deductibles, co-insurances, or copayment amounts** prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill. If you do not notify our office of a change in coverage at the time of your appointment and your claim is denied as a result, you will be responsible for the charges of the claim in full.
  To find out what your insurance plan covers and what your financial obligation may be, call the Customer Service or Member Services Department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Financial Policy My signature below acknowledges that I have read and understand the conditions for payment to Allergy & Asthma Specialists, P.C. as outlined above.

Signature:_________________________________ Date:______________________

Consent to Bill My signature below acknowledges that I give permission for Allergy & Asthma Specialists, PC to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. Such necessary information may include my diagnosis, services dates, types of service and other information related to services necessary to process claims.

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:______________________

We accept cash, personal checks, Visa, MasterCard, Discover and American Express.

History & Physical

(Please fill out completely)

Patient Information

Full Name: ______________________________ Date: ____________
Last *First* *M.I.*

How did you hear about us?: ______________________________

What has prompted your visit today?: ______________________________

What are your expectations from today's visit?: ______________________________

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? ______________________

Have your nasal symptoms progressed? ______________________

Do they interfere with your sleep or daily activities? ______________________

When are these symptoms present (circle): Spring Summer Fall Winter

Do the following worsen your symptoms: Perfume Smoke Cold air A/C

Do you have eye symptoms? ______________________

Have you noted green or yellow nasal secretions? ______________________

Number of sinus infections over the past year: ______________________

Do you have a sleep disorder or snoring? ______________________

Have you had nasal polyps? ______________________

Have you had sinus surgery, sinus Cat scan, or sinus x-ray? ____________ Dates: ____________

Name of 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

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 the 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? ____________________

Do you have heartburn? __________ How long have you had chest symptoms (yrs)? __________

Have these gotten worse over time? ____________________

List all current asthma medications:

____________________   ____________________

____________________   ____________________

____________________   ____________________

List all current physical activities:

____

____

Environmental History

Home/APT (________Floors)   No. Yrs in home __________Flooding __________

Living areas below grade? __________   No. Smokers in home__________

Heat: Hot air   Hot water   Radiant steam   electric __________

A/C: Central   Room

Humidifier (central/separate units)______Air cleaner (central/room-hepa others) ________Vacuum (central/ ______)

Bedroom: Boxspring/Mattress   Frame/Mattress   Waterbed

Pillow: Synthetic   Feather   **Comforter:** Synthetic   Feather

Allergy cover: Boxpring________Mattress________Pillow ________

Carpeting: Living area _______Basement ________Bedroom _______

Pets: ______________________________ Are they **IN** the bedroom? __________
What kind? (e.g. dog, cat?)

Name: ______________ DOB: ______________ Date: ______________

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?

____

____

____

Number of 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

Do you have a history of any of the following:

Hepatitis Thyroid problems Lupus Acid reflux

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

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 fruits or other foods? ______________

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

____

____

Do you have an Epipen? ______________

Allergy & Asthma Specialists, PC

Cancellation and Referral Policy

CANCELLATIONS

If you are unable to keep a scheduled appointment, the appointment must be cancelled 48 hours prior to appointment time. 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 to gone to another patient in need. Failure to do so may result in at $50 no show fee. Please call our main office at 978-256-4531 to cancel or reschedule an appointment or to ask any general office questions.

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:

- Reschedule your appointment.
- Sign a self referral form and pay for your visit.

NON-EMERGENCY TREATMENT WILL BE DENIED IF:

- A minor under eighteen is unaccompanied by an adult.
- A "referral" is not obtainable when required by a 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 denied another appointment.