ALLERGY & ASTHMA SPECIALISTS, P.C.

www.Allergy-Asthma.net

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Dear Patient,

Welcome to Allergy & Asthma Specialists. Thank you for choosing our practice for your allergy & asthma needs.

Please complete both sides of the **Patient Registration Form** as well as pages 1-3 of the **History & Physical Questionnaire.** Please return both forms along with your insurance cards to the office for an appointment to be booked. Once all the required information is received, we will schedule an appointment.

Please remember that if you or your child are having allergy testing, no antihistamines may be taken for 72 hours prior to the appointment. Allergy testing appointments last from one hour to two hours. If you know you must cancel an appointment, please call a minimum of 48 hour in advance (preferably 72 hours). For your 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 at Allergy & Asthma Specialists, PC

Please Note – Appointment reminders will be left at the telephone number you provided on your registration form. 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 Marital Status: ________________

Occupation ____

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 _____________________

PRIMARY INSURANCE

Relationship to patient __________________

Subscriber Name ____ Sex ____M ____F DOB _____________

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 ____ Sex ____M ___F DOB _____________

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:______________________
Full Name (If unable to capture electronic signature): ________________________________

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:______________________
Full Name (If unable to capture electronic signature): ________________________________

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:______________________
Full Name (If unable to capture electronic signature): ________________________________

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

Allergy & Asthma Specialists, PC

CONSENT TO BILL INSURANCE PLAN(S)

My signature below indicates that:

I give permission for Allergy & Asthma Specialists 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, service dates, types of service and other information related to the services necessary to process claims.

Patient Name____

Signature of Patient/Guardian____

Full Name(If unable to capture electronic signature): ______________________________

Date____

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SPECIALISTS, P.C.
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Meaningful Use Form

Meaningful Use enables significant and measurable improvements in public health through the use of electronic medical records.

Patient's Full Legal Name: ____

Date of Birth: ____

Patient/Guardian's Email Address: ____

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose "Refused to Report/Unreported".
(Please check ONE in EACH CATEGORY that applies)

RACE	ETHNICITY	PREFERRED LANGUAGE
White	Hispanic or Latino	English
Black or African American	Not Hispanic or Latino	Spanish
Hispanic	Undefined	Indian - Hindi or Tamil
Asian	Refused to Report/Unreported	Vietnamese
American Indian or Alaskan Native		Other ___________________
Native Hawaiian or other Pacific		Refused to Report/Unreported
Other Pacific Islander		
Other Race ____________		
More than one		
Undefined		
Refused to Report/Unreported		

Consent to Obtain External Prescription History

I, _____________________________ , whose signature appears below, authorize Allergy & Asthma Specialists, P.C. and Its Affiliated Providers to view the above listed patient's external prescription history via the SureScripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

____ _______________________________

Patient/Guardian Signature Date

Full Name (If unable to capture electronic signature): ____

History & Physical

(Please fill out completely)

Patient Information

Full Name: ____ Date:_______________________

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

(e.g. nasal blockage, wheezing etc.)

Please list your main symptom(s) **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, check 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: 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 if sinus infections over the past year? ____

Do you have a sleep disorder or snoring? ____

Have you had nasal polyps? ____

Have you had: Y N sinus surgery Y N sinus Cat scan Y N 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:

Check symptoms that you experience:

Wheezing | Cough | Shortness of Breath | Chest Tightness

Check the triggers that bring out your symptoms:

Cold Air | Head Colds | Pollen | Cats | Dogs
Sinus Infections | Dust | Smoke | Exertion | Mold

Check 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 (years)? ______________

Have these become worse over time? ______________________________

List all current asthma medications:

______________________ ______________________

______________________ ______________________

______________________ ______________________

List all current physical activities:

____

____

Environmental History

Home/apt (__________Floors) # Years in home ____________ Flooding_______________

Living areas below grade? _______________________ # Smokers in home_____________________________

Heat: Hot air Hot water Radiant steam Electric

A/C: Central Room

Humidifier (central/separate unit)__________ Air cleaner (central/room-hepa, others) __________ VACUUM (CENTRAL/_________)

Bedroom: Box spring/Mattress Frame/Mattress Waterbed

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

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 Food Allergy Stinging Insect 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: ___

Check all triggers that bring out 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:

Check 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? ___