Asthma & Allergy Associates P.A.

Certified: American Board of Allergy and Immunology

4601 W. 6th Street - Lawrence, Kansas 66049 - 785-842-3778 & 800-718-3778
515 SW Horne, Ste 102 - Topeka, Kansas 66606 - 785-232-9154

PLEASE FILL OUT ALL PAGES **PRIOR** TO ARRIVING AT YOUR APPOINTMENT

YOUR INITIAL ALLERGY EVALUATION IS SCHEDULED FOR:

RONALD E. WEINER, M.D. WARREN E. FRICK, M.D.

IN THE LAWRENCE OFFICE: 4601 W. 6th Street, Suite B, Lawrence, KS 66049

It is your responsibility to contact your insurance company and find out if we are "In-Network" with your specific plan. If you have questions about out of pocket costs, deductibles or charges, please call the office or your insurance PRIOR to your appointment.

Your co-pay is due at the time of service. If you do not have a co-pay, we require 20% of the total visit unless other arrangements have been made. If you do not have insurance, we require full payment. We cannot file your insurance without the current card, so please bring your insurance card and any necessary referrals that are required by your carrier. Without your insurance card and referral your appointment may have to be rescheduled.

IT IS YOUR REPONSIBILITY TO OBTAIN A REFERRAL FROM
YOUR PRIMARY CARE PHYSICIAN TO BE SEEN IN OUR OFFICE
IF YOUR INSURANCE REQUIRES IT.
WE REQUIRE ALL TRICARE, VA, and HASKELL REFERRALS TO BE AT OUR OFFICE BEFORE YOU ARE SEEN.

You may not be tested on your first visit. Please allow 2-3 hours for your initial appointment. If you are not able to keep this appointment, please call our office at least 48 hours in advance.

THANK YOU FOR YOUR CONSIDERATION & COOPERATION.
WE LOOK FORWARD TO MEETING YOU!

New Patient Registration Form

Patient Name: First_____ M.I. _____ Last _____

Address: _____

_____ _____ _____

City *State* *Zip Code*

Sex: Male ☐ Female ☐ Birthdate _____ Age _____ Social Security # _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow(er) ☐

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Employer and Occupation: _____

Have you or any member of your family ever been a patient in this office before? Yes ☐ No ☐

If YES, name and relationship _____

Primary Physician _____

Referring Health Provider _____

Race: Am Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American ☐ Native HI ☐
Other Pacific Islander ☐ White ☐ Unknown ☐ Declined ☐

Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐

Preferred Language: English ☐ Spanish ☐ Declined ☐

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Responsible Party or Bill To Information:

Full Name: _____ Relationship: _____

Address: _____

Street *City* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birthdate: _____ Age: _____ Social Security #: _____

Employer: _____

Insurance Information: *Please have your card(s) ready so that we may scan them into your record.*

Primary Insurance: _____ Policy Holder Name: _____ DOB: _____

Secondary Insurance: _____ Policy Holder Name: _____ DOB: _____

Assignment of Benefits and Authorization to Release Medical Information

I request that payment of authorized benefits, Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services. Further, I request payment of authorized Medical benefits be made to Asthma, Allergy & Rheumatology, and also authorize any holder of medical information about me to release to the named Medigap insurer any information needed to determine benefits payable for services from this provider.

Signature: _____ Date: _____

Medicare Patients Only: HIC #: _____ Medical Insurer: _____

ASTHMA & ALLERGY ASSOCIATES, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Asthma & Allergy Associates, PA Notice of Privacy Practices. My signature below indicates only that I have received the Notice, not that I have read of agree with its contents.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Parent/Guardian Name (Print) Date

EMERGENCY CONTACT INFORMATION

Name(s) _____ Relationship_____

Home Phone ( )_____ Work ( )_____ Cell Phone ( )_____

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby allow Asthma & Allergy Associates, PA to disclose the following protected health information:

Appointment Date and Times, Test Results, Account Information, Other related health information to the following people.

_____Spouse Name(s) _____

_____Parents Mother_____Father_____

_____Child Name(s)_____

_____Friend Name(s)_____

_____Other Name(s)_____

This permission will remain in effect until canceled, in writing, by the patient/guardian.

_____ _____

Date Signature of Patient/Parent/Guardian

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ALLERGY QUESTIONNAIRE

NAME _____ AGE _____ SEX _____ DATE _____

OCCUPATION _____ If filling out form for a child, list occupation of father _____, of mother _____.

Please check YES if patient has been bothered by any of the following, NO if he has not.

EYES:	burning	YES____NO____
	itching	YES____NO____
	watering	YES____NO____
	swelling	YES____NO____
EARS:	itching	YES____NO____
	drainage	YES____NO____
	ringing	YES____NO____
	popping	YES____NO____
	suspected hearing loss	YES____NO____
	fluid under eardrum	YES____NO____
	recurrent ear infections	YES____NO____
NOSE:	sneezing	YES____NO____
	itching	YES____NO____
	drainage	YES____NO____
	stuffiness	YES____NO____
	mouth breathing	YES____NO____
	nose bleeds	YES____NO____
THROAT:	itching	YES____NO____
	soreness	YES____NO____
	postnasal drainage	YES____NO____
	throat clearing	YES____NO____
CHEST:	coughing	YES____NO____
	mucous production	YES____NO____
	wheezing	YES____NO____
	shortness of breath	YES____NO____
	bronchitis	YES____NO____
	pneumonia	YES____NO____
GASTROINTESTINAL:	poor appetite	YES____NO____
	abdominal pain	YES____NO____
	bloating (gas)	YES____NO____
	vomiting	YES____NO____
	diarrhea	YES____NO____
	constipation	YES____NO____
NERVOUS SYSTEM:	headaches	YES____NO____
	unusual fatigue	YES____NO____
	irritability	YES____NO____
	convulsions	YES____NO____

SKIN: eczema YES____ NO____
hives or swelling YES____ NO____

MISCELLANEOUS: kidney or bladder disorders YES____ NO____
pain or swelling in arms or legs YES____ NO____
reactions to insect stings YES____ NO____
poor weight gain YES____ NO____

SEASONAL INCIDENCE: (Underline with one line the months in which allergy problems occur. Use 2 lines to indicate the months worst symptoms occur.

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

FAMILY HISTORY: Has any family member had any of the following conditions? (Include parents, grandparents, aunts, uncles, brothers and sisters)

Asthma YES____ NO____
Chronic bronchitis YES____ NO____
Emphysema YES____ NO____
Chronic nasal congestion, or sinus trouble YES____ NO____
Hay fever YES____ NO____
Hives YES____ NO____
Eczema YES____ NO____
Severe reactions to bee, wasp or hornet stings YES____ NO____
Suspected food or drug allergies YES____ NO____
Intestinal disorders YES____ NO____
Cystic fibrosis YES____ NO____
Migraine headaches YES____ NO____

IMPORTANT!!!!

Please be aware that some medications may prevent us from performing valid skin tests. If you are taking one of these medications, please ask the health care professional who prescribed it whether or not it is appropriate to stop such medication before coming to our office.

DRUGS THAT BLOCK ALLERGY SKIN TESTS

(in parentheses is the typical time required off the drug before valid tests can be performed)

Antihistamines – 5 days(10 if possible)

Examples include Allegra, fexofenadine, Clarinex, Claritin, any form of loratidine or cetirizine, Zyrtec, Xyzal, Atarax, hydroxyzine, and cold medicines that contain antihistamines. An exception is Benadryl(2 days may be adequate).

Tricyclic antidepressants(10 days, occasionally longer)

1. amitriptyline(Elavil, Endep, Emitrip, Enovil)
2. amoxapine(Asendin)
3. desipramine(Norpramin, Pertofrane)
4. doxepin(Adapin, Sinequan)
5. imipramine(Tofranil)
6. nortryptyline(Pamelor)
7. protryptline(Vivactil)
8. trimipramine(Surmontil)
9. clomipramine(Anafranil)

Tetracyclic antidepressants(10 days, occasionally longer)

1. maprotiline(Ludiomil)
2. mirtazapine(Remeron)

Phenothiazines(7 days)

1. chlorpromazine(Thorazine, Largactil)
2. fluphenazine(Thorazine, Prolixin)
3. perphenazine(Trilafon)
4. prochlorperazine(Compazine)
5. thioridazine(Mellaril)
6. trifluoperazine(Stelazine)

Other

1. risperidone(Risperdal) – 7 days
2. clonidine – 7 days
3. meclizine – 4 days

No effect - nifedipine , montelukast(Singulair), cimetidine, ranitidine

Apr 2016