

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 RESPONSIBILITY 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 or 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

ASTHMA & ALLERGY ASSOCIATES, P. A.

4601 W 6th, Suite B, Lawrence, KS 66049, Ph 785-842-3778, FAX 785-842-4219
515 SW Horne, Suite 102, Topeka, KS 66606, Ph 785-232-9154, FAX 785-232-1855

Ronald E. Weiner, M.D. Warren E. Frick, M.D.

ALLERGY QUESTIONNAIRE

Thank you for completing this questionnaire before coming for your appointment with Dr. Frick. Please bring the completed questionnaire with you to your appointment.

Patient Name: _____ Sex: _____ Age: _____ Date: _____
DOB _____

Is the patient a student? Yes ☐ No ☐ If so, where? _____

If so, what grade or year? _____

If in college, what major? _____

Occupation, if applicable _____

If the patient has a primary care doctor, please provide name: _____

Were you referred to Dr. Frick by:

- ☐ your primary care doctor?
- ☐ a friend/family member?
- ☐ someone other than the above? If so, please specify: _____
- ☐ provider list of insurance company?
- ☐ no one?
- ☐ I found Dr. Frick's name in the phone book/online.

Name of person completing this form: _____

Relationship to patient: _____

Please try to tell us in 5 words or less what has brought you to see Dr.

Frick: _____

Please complete the following sections depending on your concerns:

Sections 2, 4, 5 and 6 for drug allergy, insect sting allergy, rash, latex allergy.

Sections 2, 4, 5, 6 and 7 for food allergy.

All sections for asthma, hay fever, nasal/ocular allergies, sinus, other.

1. HISTORY

Duration of problem: _____ ☐hrs ☐days ☐wks ☐months ☐years
Season(s) affected: ☐winter ☐spring ☐summer ☐fall ☐na
Worst season(s): ☐winter ☐spring ☐summer ☐fall ☐na

Symptoms

If possible, please rank your first and second most bothersome symptoms:

1. _____
2. _____

Please circle the symptoms that led to this appointment even if they are not present now:

EYES

Dark circles
Burning
Itching
Watering
Redness
Swelling
Pain
Blurred vision

NOSE

Congestion
Drainage
Itchy
Sneezing
Postnasal drip
Green/yellow mucus
Nosebleeds
Sniffling
Decreased sense of smell
Decreased sense of taste
Snorting
Nasal speech
Snoring
Nasal or sinus polyps
Fracture

THROAT

Sore
Postnasal drip
Tickle
Throat clearing
Itching

CHEST

Cough
Wheeze
Short of breath
at rest
Short of breath
exertional

HEADACHE

Location _____
Quality _____
____pressure
____ache
____throbbing
____constant
____one-sided
____both sides

Other symptoms(circle or list below)

Fever
Night sweats
Weight loss unintentionally
Poor appetite

2. MEDICATIONS

Please include both prescription and over-the-counter drugs.

A. Current allergy and asthma medications

	<u>Name of drug</u>	<u>How much?</u>	<u>How often?</u>	<u>As needed or regularly?</u>	<u>How helpful is it?</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

B. Previously tried allergy and asthma medications

	<u>Name of drug</u>	<u>How much?</u>	<u>How often?</u>	<u>As needed or regularly?</u>	<u>Reason stopped</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

C. Current medications for non-allergy problems, or ☐ list attached

	<u>Name of drug</u>	<u>How much?</u>	<u>How often?</u>	<u>As needed or regularly?</u>	<u>For what problem?</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____
11.	_____	_____	_____	_____	_____
12.	_____	_____	_____	_____	_____
13.	_____	_____	_____	_____	_____
14.	_____	_____	_____	_____	_____
15.	_____	_____	_____	_____	_____
16.	_____	_____	_____	_____	_____
17.	_____	_____	_____	_____	_____
18.	_____	_____	_____	_____	_____
19.	_____	_____	_____	_____	_____
20.	_____	_____	_____	_____	_____
21.	_____	_____	_____	_____	_____
22.	_____	_____	_____	_____	_____
23.	_____	_____	_____	_____	_____
24.	_____	_____	_____	_____	_____
25.	_____	_____	_____	_____	_____
26.	_____	_____	_____	_____	_____

3. ENVIRONMENT

Primary residence

Age of dwelling _____ years

Time at this residence _____ years

Location ☐city ☐rural

A/C ☐yes ☐no

Basement ☐dry ☐damp ☐none

Pillow ☐feather ☐non-feather ☐feather and non-feather ☐none

Mattress or futon ☐yes ☐no

Bedroom carpet _____ years old ☐none

Furry pets indoors ☐none ☐cat(s) ☐dog(s) ☐other: _____

Smoke exposure indoors ☐yes ☐no

Secondary residence if applicable(_____ % of time here)

Age of dwelling _____ years

Time at this residence _____ years

Location ☐city ☐rural

A/C ☐yes ☐no

Basement ☐dry ☐damp ☐none

Pillow ☐feather ☐non-feather ☐feather and non-feather ☐none

Mattress or futon ☐yes ☐no

Bedroom carpet _____ years old ☐none

Furry pets indoors ☐none ☐cat(s) ☐dog(s) ☐other: _____

Smoke exposure indoors ☐yes ☐no

Patient smoking history

Has the patient ever smoked more than experimentally? ☐Yes ☐No

Current smoker? ☐Yes ☐No

If a current or past smoker, how many years smoking/smoked? _____

How many packs(average) a day when smoking? _____ packs per day

If patient has stopped smoking, how many years ago? _____ years ago

Hobbies

1. _____
2. _____
3. _____
4. _____

4. PAST MEDICAL HISTORY

A. Please list all surgeries and the dates they were performed:

	<u>Name of surgical procedure</u>	<u>Date performed</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

B. Please list all hospitalizations for non-surgical reasons:

	<u>Reason for hospitalization</u>	<u>Date hospitalized</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

5. FAMILY MEDICAL HISTORY

Has the patient's mother, father, sister(s) or brother(s) been affected by any of the following ailments?

	<u>Relationship to patient</u>
Asthma	_____
Hay fever	_____
Hives	_____
Eczema	_____
Immune defect/deficiency	_____
Cystic fibrosis	_____

6. DRUG ALLERGY

<u>Name of Drug</u>	<u>Approximate date of reaction</u>	<u>Symptoms caused by the drug</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

7. FOOD ALLERGY

<u>Suspected food</u>	<u>Symptoms caused by the food</u>	<u>Amount of time that passes between eating food and the start of symptoms</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Is there anything in particular you wanted to get out of coming to see Dr. Frick? Any particular question or questions you wanted to ask? Or any particular test you desired? _____

Thank you for taking the time to complete this questionnaire!

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. nortriptyline(Pamelor)
7. protriptyline(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