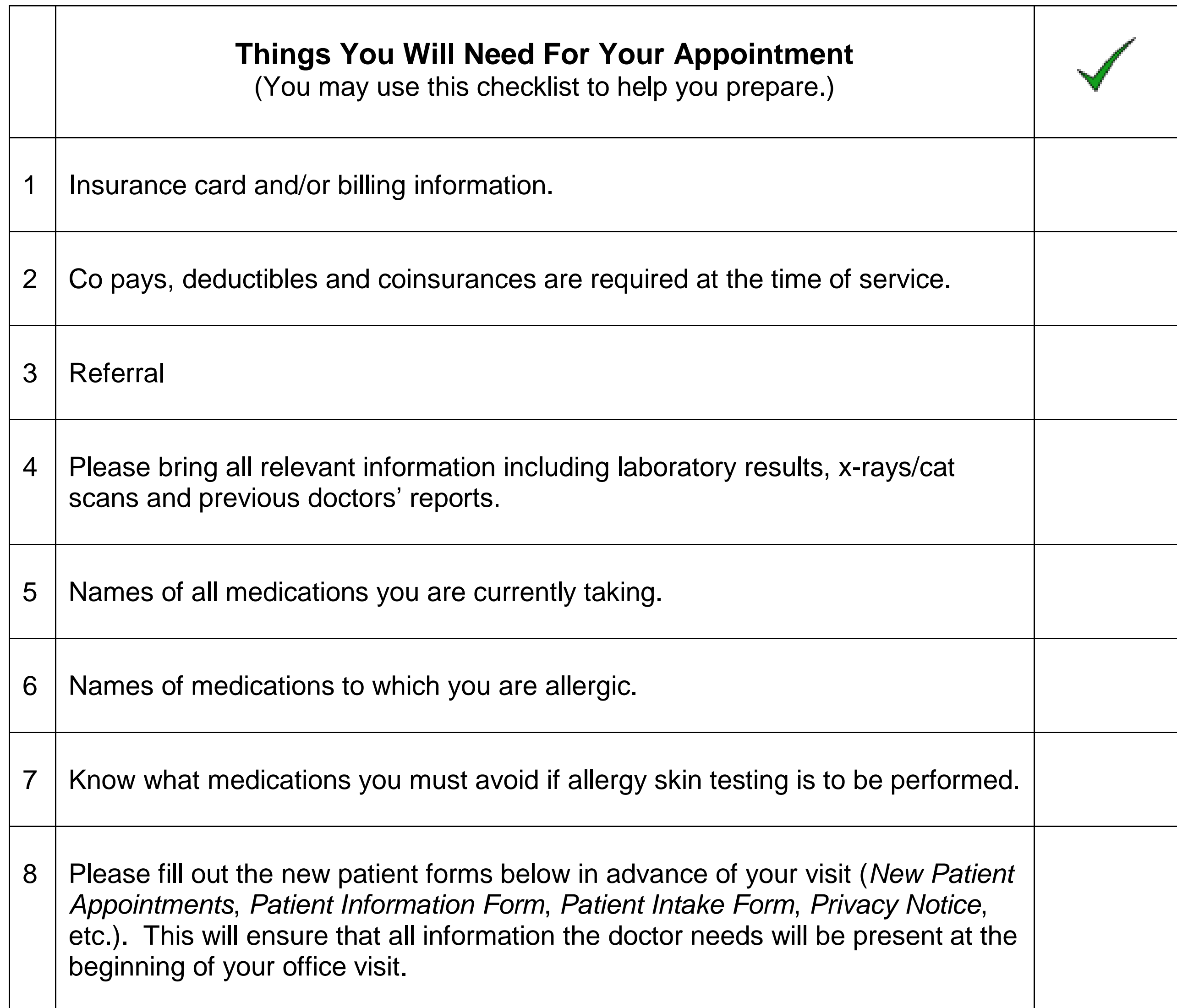
Welcome To...

BUCKS COUNTY ALLERGY & ASTHMA ASSOC.



	Things You Will Need For Your Appointment (You may use this checklist to help you prepare.)	✓
1	Insurance card and/or billing information.	
2	Co pays, deductibles and coinsurances are required at the time of service.	
3	Referral	
4	Please bring all relevant information including laboratory results, x-rays/cat scans and previous doctors' reports.	
5	Names of all medications you are currently taking.	
6	Names of medications to which you are allergic.	
7	Know what medications you must avoid if allergy skin testing is to be performed.	
8	Please fill out the new patient forms below in advance of your visit (*New Patient Appointments*, *Patient Information Form*, *Patient Intake Form*, *Privacy Notice*, etc.). This will ensure that all information the doctor needs will be present at the beginning of your office visit.	

New Patient Appointments

Please be aware that you will be here for about 1 to 2 hours for this appointment.

Please remember to stop taking any type of antihistamines (Benadryl, Claritin, Allegra, Zyrtec, etc.) 4 days prior to this appointment **unless you are being seen for eczema or hives**. Hives and eczema patients take a risk of their condition worsening if they stop their antihistamines. Please bring all insurance information, referrals, copays and any medication lists that you may have. **Do not stop taking your routine daily medications, only your antihistamines. If you have any questions regarding drugs, please call.**

Our office is **smoke free** and **perfume/cologne free** due to many patient allergies and asthma conditions. **Please do not wear perfume, cologne or scented lotions to your appointment.**

Please call our office (215-750-0315) during regular office hours if you are unable to keep this appointment. A charge of $50.00 will be incurred for any missed "New Patient" appointment unless 48 hours notice is given.

Please complete the *Patient Information Form*, *Patient Intake Form* and the *HIPPA Forms* and return them to our office on the day of your visit.

Sincerely,

Bucks County Allergy & Asthma Associates

I have read the above information.

____________________________________ _________________________

Patient Signature **Date**

Patient Information Form

Name: ____

Address: ____

City: __________________________ **State/Zip**: _____________

Email Address: ____

Phone #'s: **Home**: _________________ **Cell**: _________________

Date of Birth: _______________ **Sex**: _____ **Marital Status**: ________

Referring/Family Physician: ________________ **Phone #**: __________
(First & Last Name)

If Minor: 1st Parent/Guardian Name: ______________________________

2nd Parent/Guardian Name: ______________________________

Emergency Contact: __________________ **Phone #**: ____________

Please furnish your card(s) to be photocopied

Primary Insurance: ______________________ **Policy ID #**: ___________

Subscriber's Name: _____________________ **DOB**: ____________

Secondary Insurance: ____________________ **Policy ID #**: ___________

Subscriber's Name: _____________________ **DOB**: ____________

Responsible Party for Billing (If different then Patient)

Responsible Party Name: ______________________ **Relationship**: ________

Responsible Party DOB: _______________________ **Phone #**: __________

Address (If different then patient's address): ________________________________

I authorize the above medical group to release any records or information concerning my examination, treatment and history to my insurance company and referring physician should they request it. I hereby authorize the above group to submit a claim to my insurance carrier for all covered services and direct my insurance carrier to issue payment directly to the above medical group. I understand that I am responsible for all charges whether or not paid by the insurance along with any collection costs that might be incurred. A copy of this signature is as good as original.

Signature: ________________________ **Date**: ____________

Patient Intake Form

Today's Date: _______________
Patient Name: ____
DOB: _______________________
Pharmacy Name: ______________________________________
Phone #: ___________________

Do you have a prescription plan? (please circle) Y or N

Reason for visit:

____
____
____

Current Medication (name, dose, frequency):

____
____
____
____
____
(use reverse side if necessary)

Medication Allergies:

____
____
____

Medical History (Diabetes, Hypertension, Asthma, etc.):

____
____
____
____
____
____
____
____
____

Patient Intake Form (page 2)

Family History

Mother:
____
____

Father:
____
____

Siblings:
____
____

Smoking History: (please circle) No Active Former

# of years smoked: ___________ Packs/day: ___________ Year quit: ___________

Hobbies:
____
____

Surgeries:
____
____
____
____
____

Thank you for assisting us in updating your medical records.

Sincerely,

Dr. Spitzer