# 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:

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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/Alaska Native ☐ 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

# ASTHMA & ALLERGY ASSOCIATES, P. A.

**4601 W 6th, Suite B, Lawrence, KS 66049, Ph 785-842-3778, FAX 785-842-4219**
**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 o No o 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:

- o your primary care doctor?
- o a friend/family member?
- o someone other than the above? If so, please specify: _____
- o provider list of insurance company?
- o no one?
- o Other ?_____

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

**CHEST**
Cough
Wheeze
Short of breath at rest
Short of breath exertional

**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

**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

| | Name of drug | How much? | How often? | As needed or regularly? | How helpful is it? |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |

### B. Previously tried allergy and asthma medications

| | Name of drug | How much? | How often? | As needed or regularly? | Reason stopped |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |

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

| | Name of drug | How much? | How often? | As needed or regularly? | For what problem? |
|---|---|---|---|---|---|
| 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:

| | Name of surgical procedure | Date performed |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

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

| | Reason for hospitalization | Date hospitalized |
|---|---|---|
| 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?

| | Relationship to patient |
|---|---|
| Asthma | |
| Hay fever | |
| Hives | |
| Eczema | |
| Immune defect/deficiency | |
| Cystic fibrosis | |

## 6. DRUG ALLERGY

| Name of Drug | Approximate date of reaction | Symptoms caused by the drug |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

## 7. FOOD ALLERGY

| Suspected food | Symptoms caused by the food | Amount of time that passes between eating food and the start of symptoms |
|---|---|---|
| 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. 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