Tina C. Zecca, DO
ALLERGY & ASTHMA ASSOCIATES OF MONMOUTH COUNTY
200 White Road Ste #205
Little Silver, NJ 07739
(732) 741-8222 Little Silver
(732) 741-6217 Little Silver fax
224 Taylors Mills Road Ste #103
Manalapan, NJ 07726
(732) 847-9910 Manalapan
(732) 847-9913 Manalapan fax

Welcome to Allergy & Asthma Associates of Monmouth County! Your appointment has been scheduled in our Little Silver/Manalapan office on _____.

For your appointment, please bring all insurance cards to the office as well as any copay due. Your copay is due at the time of the visit and cannot be billed to you. If your insurance plan requires a referral, PLEASE MAKE SURE YOU CONTACT YOUR PRIMARY CARE PHYSICIAN and request the referral prior to your appointment. If you do not have a referral for your visit, your appointment will be rescheduled.

You have been scheduled for skin testing. It is very IMPORTANT that you review this medication list prior to your visit so that we may accurately diagnose your allergy. If there are any questions as to the medication that you are taking and whether or not it will interfere with skin testing, please call the office or consult with your pharmacy.

Intranasal steroid sprays and asthma medications WILL NOT INTERFERE WITH TESTING. They are as follows:
Flonase=Fluticasone, Nasonex=Mometasone, Nasacort=Triamcinolone, Rhinacort, Q-Nasl, X-Hance, Flovent Inhaler, Albuterol Inhalers, Breo, Advair, Symbicort, Dulera, Pulmicort, Arnuity, Asmanex, Qvar and Alvesco.

AVOID the following medication **5 full days prior to skin testing:**
Atarax=Hydroxyzine, Polarmine=Dexachlorpheniramine, Clarinex=Desloratadine, Xyzal=Levocetirizine, Tavist=Clemastine.

AVOID the following medications **3 full days prior to skin testing:**
Benadryl=Diphenhydramine, Phenergan cough medication=Promethazine, Bromfed, Dimetapp=Brompheniramine, Semprex-D, Zyrtec=Cetirizine, Allegra=Fexofenadine, Claritin=Loratadine, Ryvent, Ryclora.

AVOID the following nasal antihistamine sprays at least **3 days prior to skin testing:**
Dymista, Astepro, Astelin=Azelastine, Patanase=Olopatadine

PLEASE INFORM YOUR ALLERGIST IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS PRIOR TO YOUR TESTING APPOINTMENT-BUT DO NOT STOP TAKING THE MEDICATION:
Xanax-Alprazolam, Doxepin, Zyprexa=Olanzapine

PLEASE INFORM THE OFFICE IF YOU HAVE ASTHMA SYMPTOMS OR FEVER WITHIN 24 HOURS OF YOUR APPOINTMENT!!

Be advised if you arrive more than 15 minutes late for your appointment, you will be asked to reschedule as a courtesy to the doctor and your fellow patients.

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NAME: **DOB:** **AGE:**

PRIMARY CARE PHYSICIAN:

REFERRING PHYSICIAN:

PAST MEDICAL & ALLERGIC HISTORY:

Past Medical History (i.e., heart attack, bronchiolitis)

Surgeries: (please list type & year(s))

Food Reactions: (please list all foods & reaction that occurred)

Drug Reaction: (please list all drugs & reaction that occurred)

Have you ever had a reaction to latex? YES or NO Please describe your reaction:

Have you ever been stung by an insect? YES or NO Please describe your reaction:

BIRTH HISTORY (FOR AGES BIRTH TO 18)

Full Term: YES or NO Vaginal or C-Section

Birth Weight: _____ lbs. _____ oz.

Was your child breastfed? YES or NO If so, for how long?

Immunizations: Are they up-to-date? YES or NO

ENVIRONMENTAL HISTORY:

Home: House or Apartment Length of Occupancy:

Heat: Central/Forced Hot Air/Radiator **Air Conditioning**: Central/Window Unit
Humidifier: Central or Separate

Basement: Flooring-Concrete/Carpeting/Tile Is your basement musty? Damp? Does it flood? YES or NO

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Bedroom: Floor-Hardwood/Carpeting/Hardwood w/Area Rugs

Pillows: Regular or Feather **Blanket**: Regular or Feather

Pets: Dog Cat Bird Other _____ Do your pets go into the bedroom? YES or NO

SOCIAL HISTORY:

Occupation:

Marital Status: Married Single Widowed Divorced

Smoking: Do you currently smoke? YES or NO

If yes, how much do you smoke? _____ How long have you smoked? _____

If you do not smoke presently, are you a former smoker? YES or NO

If yes, how much did you smoke? _____ How long did you smoke? _____

FAMILY HISTORY:

Please list any family members with any history of allergies.

1)

2)

3)

Please list any family members with any history of asthma.

1)

2)

3)

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PATIENT NAME:

APPOINTMENT DATE:

CHIEF COMPLAINT: (Reason for Visit)

CURRENT MEDICATIONS:

DISCLOSURE RELEASE

I hereby give permission to release information about treatment given by Allergy & Asthma Associates of Monmouth County to my insurance company. I hereby give permission for my insurance company to pay Allergy & Asthma Associates of Monmouth County directly.

I realize that I am responsible for my co-pay, plus any deductible or amount indicted on my explanation of benefits, as my patient responsibility. I also realized that if my insurance requires a referral, I am responsible for acquiring one. If I fail to provide this office with a valid referral, I am responsible for the entire bill.

Unpaid balances over 45 days old will be charged a finance charge of 1.5% per month or 18% per year. If my account is sent to collections, I am responsible for all collection fees. A late fee of $10 may be charged if the copay is not paid at the time of visit. A $20 charge may be charged for any visit that has not been cancelled within 24 hours. A fee of $10 WILL BE charged for physical forms for your job, school, sports or camp activities. There will no charge for office notes sent to another physician.

Patient Name _____

Signature of Patient or Guardian _____

Date of Birth of Patient/Guardian _____

Printed Name _____

Date _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTIVE HEALTH INFORMATION

Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues if our attempts to speak with you personally have failed.
I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

___Myself only
___My spouse, significant other, or parent (specific name_____)
___Other (please specify name_____)

PLEASE CHECK YOUR CHOICE OF INFORMATION TO BE DISCLOSED

___ Yes, I give permission for medication information to be left on my answering system.
Please check if yes.
___Lab/Test results
___Diagnosis
___Prescriptions
___NO, I DO NOT WANT MEDICAL INFORMATION LEFT ON MY ANSWERING SYSTEM.

I, _____, have received a copy of the Notice of Privacy Practices.
(Patient's Name)
I understand that I have the right to revoke this authorization in writing to the office manager at ALLERGY & ASTHMA ASSOCIATES OF MONMOUTH COUNTY, 200 White Road, Suite #205, Little Silver, NJ 07739.

I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy rule or State Law.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print name of Patient or Guardian Date

_____ _____
Relationship to Patient Date

I further acknowledge that I have been informed of the new Notice of Privacy Practices under the HIPAA laws provided by the United Stated Federal Government effective September 23, 2013. A copy of the HIPAA has been offered to me via e-mail and I have been offered a copy to read in the office setting.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print name of Patient or Guardian Date

___I have chosen to have the new HIPAA laws e-mailed to my personal e-mail. Please send to this e-mail

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___I have declined to have the new HIPAA laws e-mailed to my personal e-mail.

PATIENT REGISTRATION FORM

Last Name_____ First Name_____ MI _____

Home Address _____

City _____ State _____ Zip _____

Home Phone #_____ Cell Phone #_____

Work # _____ Preferred # Home Cell Work

E-Mail Address _____ DOB _____

Employer Name & Address _____

Primary Care Dr. Name, Address & Phone _____

_____

Pharmacy Name, Address & Phone _____

_____

Mail Away Pharmacy Name (if applicable) _____

RESPONSIBLE PARTY INFORMATION

Last Name_____ First Name_____ MI _____

Home Address _____

Phone # _____ Cell # _____ Work # _____

Relationship to Patient _____ DOB _____

Employer _____

INSURANCE INFORMATION

Insurance Co. _____

Claims Mailing Address _____

ID # _____ GRP # _____

Copay_____ Policyholder Name _____

DOB _____. Relationship to Patient _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Co. _____

Claims Mailing Address _____

ID # _____ GRP # _____

Copay_____

Policyholder Name _____ DOB _____

Relationship to Patient _____ Employer _____

Signature _____ Date_____