CENTRAL INDIANA ALLERGY
www.ciallergy.com

John E. Duplantier, M.D.
Mitchell W. Smith, D.O.
Rory L. Herron, ANP-BC

New Patient Information

Arrival Time:_____
Appointment Time:_____
Date: _____

Thank you for choosing **Central Indiana Allergy**.

In order to provide the most thorough evaluation of your problems, we ask for your assistance with the following items:

- Complete the new patient questionnaire **PRIOR** to your appointment time. Central Indiana Allergy reserves the right to reschedule your appointment if the paperwork has not been completed prior to your appointment time.
- Please arrive on time for your appointment. If you are 15 minutes late, you may be asked to reschedule.
- Request that copies of pertinent medical records and test results (previous skin tests, X rays, CT scans, pulmonary function tests, and lab tests) be faxed to (317) 865-0056.
- Discontinue antihistamine medications prior to your visit (see attached list for details).
- Allow 3 hours for your initial consultation, exam, and testing.
- Please refrain from bringing food or drinks into the office.
- Please refrain from wearing perfume or cologne and from smoking before entering the office as these are triggers for patients with asthma.
- We have implemented revised billing procedures and waiting room guidelines. Please read the attached pages before your first visit.

Insurance documentation must be presented in order to be seen. Please bring you insurance card(s) with you. If your insurance requires a referral, bring the referral form with you or have it faxed to our office. If you have any questions regarding coverage for allergy evaluation or testing, check with your insurance company.

Thank you for your cooperation.
If you have questions, please call our Indianapolis office at (317) 865-0055 or our Mooresville office at (317) 584-3675.

965 Emerson Parkway, Suite B
Greenwood, IN 46143
Phone: (317) 865-0055
Fax: (317) 865-0056

902 North Samuel Moore Pkwy
Mooresville, IN 46158
Phone: (317) 865-0055
Fax: (317) 865-0056

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INSTRUCTIONS FOR NEW PATIENT AND SKIN TEST APPOINTMENTS

Stop using the following antihistamine medications 7 days prior to your appointment:

Allegra (fexofenadine)
Astelin (azelastine) nasal spray
Astepro (azelastine)
Atarax (hydroxyzine)
Clarinex (desloratadine)
Doxepin
Dymista nasal spray
Patanase nasal spray
Periactin (cyproheptadine)
Phenergan (promethazine)
Xyzal
Zyrtec (cetirizine)
Loratadine (Claritin, Alavert)

Stop the following antihistamine medications 3 days prior to your appointment:

Benadryl (diphenhydramine)
Chlortrimeton (chlorpheniramine)
"Cough and cold" combination or "Allergy" preparations that contain diphenhydramine or chlorpheniramine
Allergy eye drops
- Alomide (lodoxamide)
- Elestat (epinastine)
- Optivar (azelastine)
- Patanol, Pataday (olopatadine)
- Zaditor

Over-the-counter "allergy" eye drops (Visine, Naphcon, etc.)

There is no need to stop the following medications:

Asthma inhalers
Singulair (Montelukast)
Steroid nasal sprays
(Flonase, fluticasone, Flunisolide, Nasacort, Nasarel, Nasonex, Omnaris, Rhinocort, Veramyst)
Other medications for other medical conditions

If you are taking a beta-blocker medication (for hypertension, heart disease, or migraines), we will not be able to do allergy testing during your initial visit.

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Patient No Show Policy

We require a 72 hour notice to cancel your appointment. If you do not provide a 72 hour notice or arrive 15 minutes after your scheduled appointment time, you will be considered a "no-show". Late arrivals of 15 minutes or more will be required to reschedule their appointment.

New Patients
New patients that miss their initial appointment will not be scheduled again unless their primary care physician personally calls Central Indiana Allergy and speaks with either Dr. Duplantier or Dr. Smith. You will be advised that this is our policy if you call to reschedule after missing your initial appointment.

Established Patients
After three missed appointments patients will receive a certified letter and medical record release form dismissing them from the practice. Central Indiana Allergy reserves the right to dismiss the entire family.

Office Guidelines

Out of respect for other patients with food allergies, there is to be **NO FOOD OR DRINK** brought into the waiting room. We will place a receptacle outside the door to dispose of these items before you enter the waiting room. The only exception to this is plain bottled water.

Due to limited seating it is appreciated if only patients and their parents and/or caregiver accompany the patient in our waiting room and exam areas.

If you are bringing a child for an injection, please bring along something to keep them entertained. While we realize that it is hard to contain young children, we need to respect other patients waiting for an appointment. It is also in a child's best interest to remain calm after an injection so as to not aggravate the possibility of a reaction.

Please refrain from wearing strong perfume or cologne and from smoking before entering the office as these are triggers for patients with asthma. No weapons of any type are allowed in our office or on the premises.

Cell phones should be turned off or muted while in the waiting room. You may step outside to take a call but please let the receptionist know if you do so.

Thank you for your consideration in adhering to our office policies and procedures.

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Financial Policy

We sincerely wish to provide the best possible care. This involves mutual understanding between the patients and the CIA staff.

You are required to provide proof of insurance coverage (insurance card) at every visit. If your policy has an office visit co-payment, you agree to pay the co-payment at the time of your visit. Patients are responsible to know the terms of their insurance and whether allergy and immunology services are covered. If services are not covered, or your insurance is no longer active, you will be responsible for paying the entire balance.

As a courtesy, we will prepare and file your claim with your specific health plan (s) within timely filing limits. Failure to provide us with the correct insurance information may result in the denial of your claim. We will not file an appeal on your behalf with your insurance company. If further information from you, is requested from your health plan and not received in adequate time, the balance becomes your responsibility. You will receive an itemized statement from our office.

Requirements for maintaining your account in good standing:

1. Payment of your co-pay, co-insurance, or up to 50% of balance will be collected prior to your appointment, which is subject to your individual health policy.

2. CIA requires balances be paid under $250.00 prior to mixing immunotherapy vials, and under $500.00 for Xolair/Nucala patients.

3. For services not covered by your health plan, payment at the time of service is necessary.

4. All balances over 90 days must be paid in full. If you default on your account and it is assigned to an outside collection agency, you will be immediately dismissed from our practice. All outstanding balances, including collection fees must be paid in full before you may return to our office.

We request that your address be up to date. In the event statements are returned for an invalid address your balance will be subject to collection activity regardless of payment history.

We accept cash, checks, Mastercard, Discover and Visa. We charge $35.00 for returned checks. Patients who incur NSF/returned check charges will be required to make future payments by cash, credit card or a cashier check.

We appreciate your business and ability to continue to provide the best medical care possible. Please do not hesitate to call our office with any questions.

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New Patient Questionnaire

Name:_____ Date of visit:_____

Ref. Physician:_____ Primary Care Physician:_____

Reason(s) for visit:_____

_____

Please check the appropriate space if you have any of the following symptoms or conditions:

Nose: ☐Stuffiness ☐Discharge ☐Itching ☐Sneezing ☐Postnasal drainage
☐Decreased sense of smell ☐Frequent colds ☐Polyps ☐Nosebleeds ☐ Snoring

Sinuses: ☐Headaches ☐Sinus infections

Eyes: ☐ Itching ☐Watery discharge ☐Redness ☐Swelling

Ears: ☐Infections ☐Pressure ☐Itching

Chest: ☐Asthma ☐Emphysema/chronic lung disease ☐Tuberculosis ☐Pneumonia
☐Coughing ☐Wheezing ☐Shortness of breath ☐Tightness
☐Frequent respiratory infections ☐Coughing blood

Do any of the following factors affect your chest symptoms?
☐Upper respiratory infections ☐Exercise ☐Nighttime ☐Morning ☐Cold air
☐Allergens (e.g., dust, animals) ☐Irritants (e.g., smoke, perfume) ☐Acid reflux

Do you have year-round symptoms? ☐Yes ☐No

Please check the appropriate box if any of the following variables make your symptoms worse?
☐Spring ☐Summer ☐Fall ☐Winter
☐Inside ☐Outside ☐Home ☐Workplace
☐Exercise ☐Hobbies

Please check the appropriate box if any of the following specific items make your symptoms worse?

☐House dust	☐Raking Leaves	☐Birds	☐Insect sprays	☐Air pollution
☐Turning mattress	☐Mowing grass	☐Cats	☐Scented products	☐Temperature Change
☐Basements	☐Hay or Straw	☐Dogs	☐Tobacco smoke	☐Wind
☐Feathers	☐Barn dust	☐Horses	☐Newsprint	☐Cold/Heat
☐Cottages/cabins	☐Dampness	☐Other Animals	☐Emotional upset	☐Aspirin

Skin: ☐Hives ☐Eczema ☐Itching ☐Skin allergies (e.g., poison ivy, metal)

Suspected food allergy? □Yes □No
If yes: List suspected foods:

Indicate suspected manifestations:
□Skin □Hives □Swelling □Itching □Eczema
□Gastrointestinal □Vomiting □Cramps □Diarrhea
□Respiratory □Swelling of mouth/throat □Wheezing/asthma
□Anaphylaxis

Past Medical History

Medical Conditions (please list) **Surgeries (please list)**

Please list any previous hospitalizations or emergency room visits.
Date Hospital Diagnosis/Treatment

Current Medications:

Medication name and strength	Dose	How many times per day?

Please list allergy and asthma medications that you have tried in the past:

Have you ever had allergic reactions to any of the following? If yes please give details.

□Medications

□Insect stings (e.g., bees, wasps, hornets, yellow jackets, fire ants)

□Latex

If you have had any radiographic studies, please indicate date and facility where these studies were done:
Chest X-ray
□Chest CT
□Sinus X-ray
□Sinus CT
□Bone density scan
□Other:_____

Have you ever had allergy testing done in the past? □Yes □No
If yes, indicate approximate date, physician and results.

Environmental History:
In what type of home do you live?
□House □Apartment □Other (describe):_____
How old is your home?_____ How long have you lived there?_____
Please indicate the location of your home:
□Urban □Suburban □Rural □Wooded □Industrial
Smoking in home: □No □Yes
Heating system: □Forced air □Other (describe):_____
Air conditioning: □Central □Room □None
Humidifier: □Central □Room/portable □None
Basement: □Yes □No
If yes, does the basement smell musty? □Yes □No
Bedroom:
Mattress type:_____
Pillow type:_____
Bedding type:_____
Allergy-proof covers?_____
Flooring type:_____
Pets allowed?_____
Household pets (please types and numbers of pets):

Family History:
Please indicate whether there is a history of asthma, allergic rhinitis (hay fever), sinusitis, eczema, hives, food allergy or recurrent infections/immunodeficiency in any of the following individuals:

Mother:
Father:
Siblings:
Children:

Social History:
Occupation:
Workplace exposures?
If a child
grade in school:_____
Day care attendance?
Marital status: □Married □Single □Divorced □Widowed

Children:
Smoking status: □Never □Current smoker □Ex-smoker
If you are a current or ex-smoker, please indicate:
Number of packs per day?_____ Number of years?_____
Any second-hand tobacco smoke exposure?
Alcohol use?
Recreational drug use?

Review of Systems:

General Health:	□Good □Fair □Poor □Weight loss □Weight gain □Fevers
Eyes:	□Glasses □Contact lenses □Glaucoma □Visual impairment
Head/Neck:	□Migraine headaches □Bad breath □Nosebleeds □Broken nose □Ringing in ears □Hearing impairment □Hoarseness
Cardiovascular:	□Heart murmur □Palpitations □Chest pain □Heart attack □Blood clots □Easy bruising □Swelling of legs
Gastrointestinal:	□Heartburn □Difficulty swallowing □Vomiting □Ulcers □Pain/cramps □Constipation □Diarrhea □Blood in stool □Hepatitis □Yellow jaundice □Pancreatitis □Gall bladder problems
Genitourinary:	□Difficulty urinating □Blood in urine □Painful urination □Incontinence □Bladder/kidney infections □Kidney stones □Yeast infections □Menstrual abnormalities
Skin:	□Acne □Psoriasis □Other
Blood/Lymph:	□Anemia □Blood disorder □Swollen lymph glands
Cancer:	□No □Yes If yes, list type, site, and current status:
Musculoskeletal:	□Joint pain □Back pain □Osteoporosis □Rheumatoid arthritis □Fibromyalgia □Lupus □Other
Endocrine:	□Heat/cold intolerance □Thyroid disease □Diabetes
Neurologic:	□Stroke □Dizziness □Numbness □Vertigo □Tingling □Extremity weakness □Bell's palsy
Psychiatric:	□Depression □Anxiety □Mood disorder □Schizophrenia □Suicidal thoughts/attempts □Substance abuse □Other:
Infections:	□Up to date immunizations □Yearly flu immunization □Pneumovax □Recurrent infections (list locations) □Unusual/opportunistic infections □Fungal infections

Entire form reviewed in office on _____ with_____/_____