

**Western Springs Asthma & Allergy. S.C.**

5600 S. Wolf Road, Suite 135

Western Springs, IL 60558

**INSTRUCTIONS FOR NEW PATIENTS**

1. Before your visit, please print out pages 2-6 below, which include:

- ♦ Registration form (your printer may alert you that margins are too wide; it is okay to print)
- ♦ Office Policies and Financial consent
- ♦ Consent for Release and Use of Confidential Information
- ♦ New Patient Questionnaire (2 pages)

***Please review pages 7&8***, which list **medications** that may need to be stopped (see #4 on this page).

2. Please bring the following to your visit:

- ♦ Insurance card – this is also needed at follow-up visits since contracts or member numbers can change without the patients' knowledge. We use it to verify current coverage and benefits.
- ♦ Referral if you have HMO insurance; we may not be able to see you without it.
- ♦ Picture form of identification, such as a driver's license (for identity theft protection).
- ♦ ***Forms: please fill them out before your arrival as described above or come 15 minutes early.***
- ♦ Medication names: please have the names of **ALL** prescription and non-prescription medicines and their doses, both current ones and those recently taken
- ♦ ***Request prior records*** you feel would help the doctor, including allergy testing, breathing tests, CT scans or X-rays, etc.; if we have to request them after your visit, it delays aspects of your care.

3. Call your insurance company to check your benefits. You may have a:

- ♦ Specialist co-pay for office visits, which is due at the time of your appointment.
- ♦ Deductible for the office visit and/or allergy testing. If needed, the two procedure codes for allergy skin testing are 95004 (most often used) and 95024 (less often).

4. Please review the medication list on pages 7&8 to see if any need to be stopped before the visit in case allergy testing will be done.

- Please do not stop any medications that are not on the list. This includes medications for asthma, blood pressure, diabetes, cholesterol, pain relief, neurological conditions and antibiotics. Please call our office if you are not sure.
- Continue your antihistamine if you cannot stop due to severe itching or an acute allergic reaction. We can still evaluate and treat you, postponing testing for another time.

***We look forward to meeting you and caring for you and your family.  
If you have problems with these instructions, please call our office at 708-246-4515.***

**Western Springs Asthma & Allergy. S.C.**

5600 S. Wolf Road, Suite 135

Western Springs, IL 60558

**REGISTRATION**

**PATIENT INFORMATION**

Legal Name: First \_\_\_\_\_ Last \_\_\_\_\_ M \_\_\_\_\_

Nickname \_\_\_\_\_ Gender: M F Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_ Student: Yes No

Marital Status of Patient: Single Married Divorced Separated Widowed

Responsible Financial Party: Self Father Mother Other (specify) \_\_\_\_\_

Name of Parents or Legal Guardian (if minor) \_\_\_\_\_

Marital Status of Parents (if minor): Single Married Divorced Separated Widowed

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referred By \_\_\_\_\_ Phone \_\_\_\_\_

Preferred local pharmacy name & phone: \_\_\_\_\_

Mail-order pharmacy company and fax number (if applicable): \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY** Co-Pay \$ \_\_\_\_\_

Insurance Company \_\_\_\_\_

Legal Name of Insurance Holder: First \_\_\_\_\_ Last \_\_\_\_\_ M \_\_\_\_\_

Insured's birthdate \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Relationship to Patient: Self Spouse Father Mother Other \_\_\_\_\_

Insured's Information if different: Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

ID # or Medicare # \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY**

Insurance Company \_\_\_\_\_

Legal Name of Insurance Holder: First \_\_\_\_\_ Last \_\_\_\_\_ M \_\_\_\_\_

Insured's birthdate \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Relationship to Patient: Self Spouse Father Mother Other \_\_\_\_\_

ID # or Medicare # \_\_\_\_\_ Group # \_\_\_\_\_

**SIGNATURE**

**DATE**



\_\_\_\_\_



\_\_\_\_\_

**Western Springs Asthma & Allergy. S.C.**  
5600 S. Wolf Road, Suite 135  
Western Springs, IL 60558

**OFFICE POLICIES & FINANCIAL CONSENT**

**\*\*\*\* Please read this carefully and completely\*\*\*\***

- ♦ **For PPO's and HMO's**, I give my permission for my insurance company to be billed and for payment to be made directly to my physician.
- ♦ **For Medicare patients**, I agree to pay in full at the time of service for charges related to the office visit and any tests or procedures. Medicare will reimburse me for the majority of the office charges. [This is our practice's method of handling Medicare patients as non-participating providers.]
- ♦ **HMO Patients**: prior authorization is required prior to each service, and must be presented at the time of service. **Obtaining a valid referral is the responsibility of the patient or guardian.**
- ♦ Co-payments are due at the **time of the visit**. If a co-payment is not provided the office reserves the right to reschedule my appointment.
- ♦ Until deductibles are met, all services will be paid in full regardless of type of insurance.
- ♦ You are responsible for all balances due once your insurance company has responded to the bill. All payments not received by the statement due day will be considered delinquent and appropriate collection action will be taken.
- ♦ If not covered by insurance, payment is required on the date services are rendered. [Arrangements to accommodate financial needs can be discussed.]
- ♦ Our office accepts cash, checks and VISA/Mastercard; American Express may be added (please ask)

Please **[X]** the following once you have read them:

There will be a **\$10.00 late fee** assessed **monthly** to accounts that are past due.

There will be a **\$35.00 charge** for no-shows or late cancellation for returning patients. Not showing up affects not only you and the physician, but also someone else who could have had the appointment time. Please note this is not covered by insurance and is your responsibility.

There will be a **\$65.00 charge** for a new patient appointment no-show or late cancellation. Be courteous to other patients in need of an appointment and cancel within 24 hours. Please note this is not covered by insurance and is your responsibility.

There will be a **\$20.00** charge for rewriting prescriptions already directly given to the patient.

**Three (3) No-Show** appointments may result in patient termination from the practice.

**I have read and understand this policy. By signing, I agree to pay any fees that apply as above.**

 \_\_\_\_\_  
Patient name

 \_\_\_\_\_  
Signature of patient or guardian

 \_\_\_\_\_

**Western Springs Asthma & Allergy. S.C.**  
5600 S. Wolf Road, Suite 135  
Western Springs, IL 60558

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I understand that under the Health Insurance Portability Accountability Act (HIPAA) of 1996, I have certain rights to privacy in regards to my personal health information. I understand that the office may modify its Notice of Privacy Practice from time to time, and that I can request a copy at any time or view it on the practice website (on "Our Practice" page). I have a right to request in writing how my personal health information is disclosed; I can revoke this consent in writing, except to the extent actions were taken in the past that relied on this consent.

- Yes, I would like a copy of the Notice of Privacy Practice.  
 No, I would not like a copy of the Notice of Privacy Practice.

**X** \_\_\_\_\_  
Patient name

**X** \_\_\_\_\_  
Signature of patient or guardian

**X** \_\_\_\_\_  
Date

**PERSONAL HEALTH INFORMATION RELEASE**

I give my consent for the practice to contact me by mail and to leave messages with my medical information at these numbers or with the following people (leave blank if not applicable):

Home phone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cell phone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work voicemail:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Co-worker:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home fax:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Work fax:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Additional contacts (other than parents/guardians of a minor):**

\_\_\_\_\_  
Name of person we may contact                      Relationship                      Phone #1                      Phone #2

\_\_\_\_\_  
Name of person we may contact                      Relationship                      Phone #1                      Phone #2

\_\_\_\_\_  
Name of person we may contact                      Relationship                      Phone #1                      Phone #2

**I agree to the above statements:**

Signature: **X** \_\_\_\_\_ Date: **X** \_\_\_\_\_

If you are not the patient, please specify your relationship: \_\_\_\_\_

NEW PATIENT QUESTIONNAIRE – PAGE 1

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Reason for your visit (briefly describe symptoms/concerns – the doctor will go into more detail):

\_\_\_\_\_  
\_\_\_\_\_

Medications/treatments you have tried for this problem (Please add if they helped/didn't help or if any side effects)

\_\_\_\_\_

CURRENT medicines and daily dose (RXs, OTC, sprays, eye drops, creams, supplements/vitamins; If > 6, please bring list.)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

[ ] Yes [ ] No Medication allergies, such as pain relievers, antibiotics, others (list name, when occurred, symptoms):

\_\_\_\_\_  
\_\_\_\_\_

[ ] Yes [ ] No Food reactions (list food/symptoms) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

[ ] Yes [ ] No Insect sting reactions \_\_\_\_\_ [ ] Yes [ ] No Latex reactions

[ ] Yes [ ] No Chemicals/poison ivy/bandages/tape reactions (circle) [ ] Yes [ ] No IV dye reactions

Medical problems [why current medicine(s) being taken]: 1. \_\_\_\_\_; 2. \_\_\_\_\_;

3. \_\_\_\_\_; 4. \_\_\_\_\_; 5. \_\_\_\_\_; 6. \_\_\_\_\_

Past hospitalizations or surgeries: \_\_\_\_\_

\_\_\_\_\_

Infections (how many per year): Ear: \_\_\_\_\_ Sinus: \_\_\_\_\_ Skin: \_\_\_\_\_

Pneumonia: (how many ever total) \_\_\_\_\_; Date of last one: \_\_\_\_\_ Infections ever needing IV/hospital: [ ] Yes [ ] No

Social history

Patients under 12 yrs: Full term? [ ] Y [ ] N C-section? [ ] Y [ ] N Breast-fed? [ ] Y [ ] N Formula problems? [ ] Y [ ] N

Patient smokes: [ ] No [ ] Yes -> Smoking history: \_\_\_\_\_ years for \_\_\_\_\_ packs/day; quit smoking? [ ] No [ ] Yes, when \_\_\_\_\_

Alcohol [ ] No [ ] Yes (type/how many): \_\_\_\_\_ per week [ ] No [ ] Yes Marijuana use: \_\_\_\_\_

Smokers in home [ ] Yes [ ] No Use of plug-in fresheners/diffusers/lit scented candles [ ] Yes [ ] No

Current/former occupation: \_\_\_\_\_ Hobbies/types of exercise: \_\_\_\_\_

Pets in home [ ] No [ ] Yes (types): \_\_\_\_\_ Pets allowed in bedroom [ ] Yes [ ] No

Age of mattress: \_\_\_\_\_ Age of pillow: \_\_\_\_\_ Allergy covers [ ] Y [ ] N Room HEPA [ ] No [ ] Yes, where \_\_\_\_\_

Home [ ] Owned [ ] Rented Oldest wall-to-wall carpet age: \_\_\_\_\_ [ ] N/A Which room(s) \_\_\_\_\_

Basement: [ ] No [ ] Yes -> Carpeted? [ ] Yes [ ] No Home dampness/seepage/mold [ ] Yes [ ] No

Who lives at home: \_\_\_\_\_ For child: Childcare/sitter [ ] Yes [ ] No

[ ] Different home? (parent, vacation): How often there \_\_\_\_\_ Pets: [ ] Y: \_\_\_\_\_ [ ] N Smokers [ ] Y [ ] N

For other home: Oldest carpet age: \_\_\_\_\_ Age of mattress: \_\_\_\_\_ Age of pillow: \_\_\_\_\_ Allergy covers? Y N

**NEW PATIENT QUESTIONNAIRE – PAGE 2**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

*Patients under 21 years old:* **Immunizations** up-to-date [ ] Yes [ ] No

*Patients over 21 years old:* Have you ever had pneumonia vaccine (Pevnar/Pneumovax)? [ ] Yes [ ] No [ ] Unsure

If had pneumonia vaccine, last year given \_\_\_\_\_

Last year received influenza vaccine \_\_\_\_\_ or [ ] never had, why? \_\_\_\_\_

**Family history** (Any 1<sup>st</sup> degree relative with nasal allergy/asthma, eczema, drug or food allergy, autoimmune disease?)

\_\_\_\_\_  
\_\_\_\_\_

**Please circle the symptoms that apply to the patient in the PAST 6 MONTHS:**

General: Poor Appetite      Unexplained Weight Loss or Weight Gain      Lack of Energy/Fatigue      Poor Sleep

Eyes: Itchy      Red      Burning      Tearing      Mucus      Vision Problems

Ears: Painful      Clogged      Drainage      Frequent Ear Infections      Decreased Hearing

Nose: Congestion      Sneezing      Itching      Dripping      Loss of Smell or Taste      Bleeding

Throat: Painful      Irritated      Hoarseness      Throat Clearing      Burning      Swelling

Sinus: Pain      Pressure      Drainage      Frequent Upper Teeth Discomfort

Respiratory: Shortness of Breath      Cough      Wheezing      Chest Tightness      Congestion      Snoring      Apnea

Cardiovascular: Murmur      Palpitations      Fainting      Chest Pain with Exertion      High Blood Pressure

Gastrointestinal: Nausea      Vomiting      Diarrhea      Reflux      Abdominal Pain      Cramping

Gas      Constipation      Blood in Stools      Food Getting Stuck      Trouble Swallowing

Hematologic/Immunologic: Easy Bruising      Swollen Lymph Nodes      Unusual Infections      Clotting problems

Skin: Rash      Swelling      Hives      Eczema      Rough Patches      Itching      Burning      Pigment Change

Musculoskeletal: Joint ache/stiffness      Joint swelling/redness      Weakness      Spasms      Development issues (child)

Neurologic: Headaches      Dizziness/Vertigo      Altered Sensation      Migraine      Seizures      Tics

Urinary: Trouble Urinating      Blood in Urine      Enlarged Prostate      Kidney Stones      Bladder Infections

Gynecologic: Menstruating? N/A Y      Abnormal Bleeding Y N      Planned Pregnancy Soon? Y N N/A

Psychological: Learning issues      Anxiety      Depression      ADD/ADHD      Panic Attacks      Mood Swings      Autism spectrum

Form completed by \_\_\_\_\_ Relation to patient \_\_\_\_\_

**Nurse and doctor use only:**

\_\_\_\_\_  
\_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATIONS NEEDED TO BE STOPPED PRIOR TO THE VISIT (2 PAGES)**

The following antihistamine medications will interfere with allergy testing. Please review and stop them as listed. Call if you are not sure about your medications' ingredients.

**You \*\*DO NOT\*\* need to stop asthma, blood pressure, diabetes, ADHD, etc. medications or these:**

- ♦ Montelukast (Singulair)
- ♦ Nasal steroids, such as Flonase (fluticasone), Nasacort, Rhinocort, Nasonex (mometasone), etc.
- ♦ Eye drops
- ♦ PPIs for heartburn/GERD, like omeprazole, Prilosec, Prevacid, Nexium, Protonix, Dexilant, etc.

**ORAL ANTIHISTAMINES: \*\*PLEASE STOP\*\* these antihistamines **FIVE (5) days** before visit:**

- Allegra
- Benadryl
- cetirizine (Aller-tec, Wal-Zyr)
- Claritin
- Clarinex
- cyproheptadine
- desloratadine
- diphenhydramine
- doxepin
- doxylamine (found in many cold & flu nighttime relief products, such as NyQuil)
- fexofenadine (Aller-ease, Aller-fex, Wal-Fex)
- hydroxyzine (generic Atarax, Vistaril)
- levocetirizine
- loratadine (Aller-clear, Wal-itin)
- Periactin
- Xyzal
- Zyrtec
- **Continue your oral antihistamine if you cannot stop due to severe itching, hives or allergic reaction. We can still evaluate and treat you, postponing testing for another time.**

**NASAL ANTIHISTAMINES (\*\*PLEASE STOP\*\* these **3 days** before visit):**

- azelastine (Astelin, Astepro)
- Dymista
- olopatadine/Patanase

**Some heartburn (GERD) medications: \*\*PLEASE STOP\*\* these **2 days (48 hours)** before the visit:**

- cimetidine (Tagamet)
- ranitidine (Zantac)
- nizatidine (Axid)
- famotidine (Pepcid)

**MEDICATIONS NEEDED TO BE STOPPED PRIOR TO THE VISIT (PAGE 2)**

**ASTHMA MEDICATIONS**

If possible, do not take any of the following inhaled medicines for **at least six (6) hours** prior to your visit. Of course, if you are having trouble breathing, please do take them. Continue any other asthma medications not listed here.

- Albuterol (ProAir, Proventil, Ventolin)
- Combivent
- Levalbuterol (Xopenex)
- Duoneb (albuterol + ipratropium)
- Ipratropium

**ANTIDEPRESSANTS, ANTI-ANXIETY, OTHER PSYCHIATRIC MEDICATIONS**

(Discontinue **48 hours** before testing **\*\*only\*\*** if cleared with prescribing physician)

Alprazolam/Xanax	Effexor/Effexor XR	Paxil
Amitriptyline/Elavil	Elavil	Protiptyline/Triptil/Vivactil
Amoxaine/Ascedin	Imipramine/Tofranil	Prozac
Buspar	Lexapro	Restoril
Clomipramine/Anafranil	Lorazepam/Ativan	Serzone
Clonazepam/Klonoin	Librax	Trazodone/Desyrel
Celexa	Mapotiline/Ludiomil	Trimipramine/Surmontil
Cymbalta	Mirtazapine/Remeron	Welbutrin (Bupropion)
Desipramine/Norpramin	Nefazodone/Serzone	Xanax
Doxepin	Nortriptyline/Aventyl/Pamelor	Zoloft

***If you are on a medication for anxiety or depression that you do not see on the list, please call us to confirm.***

## DIRECTIONS TO WESTERN SPRINGS ASTHMA & ALLERGY

*There is also a link to our address on Google Maps on our website.*

### From the east:

Take any major westbound street to La Grange Rd/Mannheim; take to 55<sup>th</sup> Street and turn westbound. Proceed 1.5 miles to Wolf Road and follow directions below for “**From the corner of Wolf Road and 55<sup>th</sup> Street**”.

### From the south:

**Option A: From Willow Springs Road or La Grange Road heading north:** Turn left at 55<sup>th</sup> Street, proceed to Wolf Road and turn left. Follow directions below for “**From the corner of Wolf Road and 55<sup>th</sup> Street**”.

**Option B: Heading north on I-294 North and exiting at Wolf Road** or otherwise taking **Wolf Road north from points south**, about ½ mile north of Plainfield Road, look for our entrance on the left, immediately north of Park Place. Park in the rear of the building and enter through the steps to the left of the Western Springs Family Practice.

### From the west:

**Option A: I-55 North, exiting at County Line Rd North:** pass Plainfield Rd. and turn right on 55<sup>th</sup> Street. Turn right at first light, Wolf Road. Follow directions below for “**From the corner of Wolf Road and 55<sup>th</sup> Street**”.

**Option B: I-88 East to I-294 South to Ogden Avenue East:** Proceed to Wolf Road and turn right. Travel 2 miles, passing through the town of Western Springs and 47<sup>th</sup> Street, continuing to 55<sup>th</sup> Street. Follow directions below for “**From the corner of Wolf Road and 55<sup>th</sup> Street**”.

### From the north:

**Option A: I-294 South to Ogden Avenue East:** Turn right at first light, Wolf Road. Travel 2 miles, passing through the town of Western Springs and 47<sup>th</sup> Street, continuing to 55<sup>th</sup> Street.

**Option B: From Wolf Rd southbound:** Pass through Western Springs, continue to 55<sup>th</sup> Street.

Follow directions below for “**From the corner of Wolf Road and 55<sup>th</sup> Street**”.

### From the corner of Wolf Road and 55<sup>th</sup> Street (heading south):

- Go one block south to 5600, on the right.
- Before you reach our address, you will pass a small strip mall, an apartment complex and a chain link fence *immediately* before (north of) the driveway into the medical complex.
- If you reach Park Place, you have just passed the driveway.
- There is a business sign and flagpole in front of the building.
- Park in the rear of the building and enter through the steps in front to the left of Western Springs Family Practice; we are directly above them on the second floor.
- There is a lift for those with difficulty managing the stairs once inside. If you need assistance entering the stairs into the building, please call us in advance for further instructions. There is a wheelchair accessible entrance via the Western Springs Family Practice below us while they are open.

**OUR PHONE NUMBER: 708-246-4515**