

Asthma & Allergy Associates PA
Certified: American Board of Allergy and Immunology

4601 W. 6th St, Ste B - Lawrence, Kansas 66049
www.asthma-allergy-kansas.com
785-842-3778 Fax: 785-842-4219

PLEASE FILL OUT ALL PAGES **PRIOR** TO ARRIVING AT YOUR APPOINTMENT

YOUR INITIAL ALLERGY EVALUATION IS SCHEDULED FOR:

RONALD E. WEINER, M.D.

WARREN E. FRICK, M.D.

IN THE LAWRENCE OFFICE: 4601 W. 6th St, 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 your insurance PRIOR to your appointment.

Your co-pay is due at the time of service. 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 or 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

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ALLERGY QUESTIONNAIRE

NAME _____ AGE _____ SEX _____ DATE _____

PREFERRED PRONOUNS _____ OCCUPATION _____ If filling out form for a child, list occupation of father _____, of mother _____. Please check YES if patient has been bothered by any of the following, NO if patient has not.

EYES:

Burning	YES _____ NO _____
Itching	YES _____ NO _____
Watering	YES _____ NO _____
Swelling	YES _____ NO _____

EARS:

itching	YES _____ NO _____
Drainage	YES _____ NO _____
Ringling	YES _____ NO _____
Popping	YES _____ NO _____
Suspected hearing loss	YES _____ NO _____
Fluid under eardrum	YES _____ NO _____
Recurrent ear infections	YES _____ NO _____

NOSE:

Sneezing	YES _____ NO _____
Itching	YES _____ NO _____
Drainage	YES _____ NO _____
Stuffiness	YES _____ NO _____
Mouth breathing	YES _____ NO _____
Nose bleeds	YES _____ NO _____

THROAT:

Itching	YES _____ NO _____
Soreness	YES _____ NO _____
Postnasal drainage	YES _____ NO _____
Throat clearing	YES _____ NO _____

CHEST:

Coughing	YES _____ NO _____
Mucous production	YES _____ NO _____
Wheezing	YES _____ NO _____
Shortness of breath	YES _____ NO _____
Bronchitis	YES _____ NO _____
Pneumonia	YES _____ NO _____

GASTROINTESTINAL:

Poor appetite	YES _____ NO _____
Abdominal pain	YES _____ NO _____
Bloating (gas)	YES _____ NO _____
Vomiting	YES _____ NO _____
Diarrhea	YES _____ NO _____
Constipation	YES _____ NO _____

NERVOUS SYSTEM:

Headaches	YES _____ NO _____
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Unusual fatigue YES _____ NO _____
Irritability YES _____ NO _____
Convulsions YES _____ NO _____

SKIN: Eczema YES _____ NO _____
Hives or swelling YES _____ NO _____

MISCELLANEOUS: Kidney or bladder disorders YES _____ NO _____
Pain or swelling in arms or legs YES _____ NO _____
Reactions to insect stings YES _____ NO _____
Poor weight gain YES _____ NO _____

SEASONAL INCIDENCE: Underline with one line the months in which allergy problems occur. Use 2 lines to indicate the months in which worst symptoms occur.

Jan Feb Mar Apr May June July Aug Sep Oct Nov Dec

FAMILY HISTORY: Has any family member had any of the following conditions? (Include parents, grandparents, aunts, uncles, brothers, and sisters)

Asthma YES _____ NO _____
Chronic bronchitis Yes _____ NO _____
Emphysema YES _____ NO _____
Chronic nasal congestion, or sinus trouble YES _____ NO _____
Hay fever YES _____ NO _____
Hives YES _____ NO _____
Eczema YES _____ NO _____
Severe reactions to bee, wasp or hornet stings YES _____ NO _____
Suspected food or drug allergies YES _____ NO _____
Intestinal disorders YES _____ NO _____
Cystic fibrosis YES _____ NO _____
Migraine headaches YES _____ NO _____

HOW DID YOU HEAR ABOUT US? My primary care doctor YES _____ NO _____
Doctor other than primary care: _____ YES _____ NO _____
A friend/family member YES _____ NO _____
Provider list of insurance company YES _____ NO _____
No one YES _____ NO _____
Other: _____

DID YOU HEAR ABOUT OUR OFFICE FROM ANY OF THESE SOURCES:
Our clinic Facebook page YES _____ NO _____
Our clinic web page YES _____ NO _____
Television ad YES _____ NO _____
Other website YES _____ NO _____

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

(the typical time required off the drug before valid tests can be performed is in parentheses)

Antihistamines – (5 days)

Examples include Allegra, fexofenadine, Clarinex, Claritin, any form of loratidine or cetirizine, Zyrtec, Xyzal, Atarax, hydroxyzine, doxylamine succinate, and cold medicines that contain antihistamines. An exception is **azelastine nasal spray** (2 days).

Tricyclic antidepressants

1. amitriptyline(Elavil, Endep, Emitrip, Enovil) - (7 days)
2. amoxapine(Asendin) - (7 days)
3. desipramine(Norpramin, Pertofrane) - (2 days)
4. doxepin(Adapin, Sinequan) - (6 days)
5. imipramine(Tofranil) - (10 or more days)
6. nortriptyline(Pamelor)- (7 days)
7. protryptiline(Vivactil) - (7 days)
8. trimipramine(Surmontil) - (7 days)
9. clomipramine(Anafranil) - (7 days)

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)

Benzodiazepines (7 days)

1. clonazepam
2. diazepam
3. lorazepam
4. midazolam

Other (3-7 days)

1. risperidone(Risperdal) (7 days)
2. clonidine (7 days)
3. meclizine (4 days)
4. bupropion (3 days)
5. eszopiclone (3 days)
6. quetiapine (7 days)
7. trazodone (3 days)
8. zolpidem (3 days)

No effect - nifedipine, montelukast (Singulair), cimetidine, ranitidine, Mucinex, all SSRI's (eg Paroxetine, escitalopram, Lexapro, Prozac, fluoxetine).

Jan 22, 2024