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.

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REGISTRATION

PATIENT INFORMATION

Legal Name: First ______________________ Last ________________________ M ____________

Nickname ____________________ Gender: M F Birthdate _____________ Age ______

Address ____

City ____ State _______ Zip _______________

Phone: Home __________________ Work ___________________ Cell ___________________

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 _____________________

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 _____________________

Relationship to Patient: Self Spouse Father Mother Other ______________

ID # or Medicare # ______________________________ Group # ___________________________

SIGNATURE

DATE

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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.

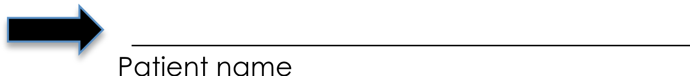
[ ] There will be a **$35.00 charge** for no-shows for returning patients. Not showing up affects not only you and the physician, but also someone else who could have had the appointment time. Please note this is not covered by insurance and is your responsibility.

[ ] There will be a **$65.00 charge** for a new patient appointment no-show.
Be courteous to other patients in need of an appointment and cancel within two business days. Please note this is not covered by insurance and is your responsibility.

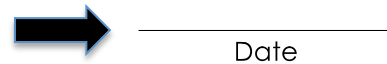
[ ] There will be a **$20.00** charge for rewriting prescriptions already directly given to the patient.

[ ] **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


Date

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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 ____ **X** _________________
Signature of patient or guardian 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:	[ ] Yes	[ ] No	Cell phone:	[ ] Yes	[ ] No
Work voicemail:	[ ] Yes	[ ] No	Co-worker:	[ ] Yes	[ ] No
Home fax:	[ ] Yes	[ ] No	Work fax:	[ ] Yes	[ ] 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: [ ] Yes [ ] No Smokers [ ] Yes [ ] No

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 (Prevnar/Pneumovax)? [ ] Yes [ ] No [ ] Unsure

If had pneumonia vaccine, last year given ______

Last year received influenza vaccine___________ or [ ] never had, why?_______________________________________

Family history (Any 1st degree relative w/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__________

Western Springs Asthma & Allergy. S.C.

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, 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
- fexofenadine (Aller-ease, Aller-fex, Wal-Fex)
- hydroxyzine (generic Atarax, Vistaril)
- levocetirizine
- loratadine (Aller-clear, Wal-itin)
- Periactin
- Xyzal
- Zyrtec

- Other over-the-counter allergy and cold preparations, such as Actifed, Contac, Drixoral, Dallergy, Dimetapp, Tavist, Tylenol Allergy or Advil. This also applies if any of these are combined with a decongestant, such as Allegra-D or Claritin-D, as well as any OTC medicine ending in "P.M.".
- **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 (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)
- nizatidine (Axid)
- ranitidine (Zantac)
- 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 (Buproprion)
Desipiramine/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 55th Street and turn westbound. Proceed 1.5 miles to Wolf Road and follow directions below for **"From the corner of Wolf Road and 55th Street**".

From the south:
Option A: From Willow Springs Road or La Grange Road heading north: Turn left at 55th Street, proceed to Wolf Road and turn left. Follow directions below for **"From the corner of Wolf Road and 55th 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 55th Street. Turn right at first light, Wolf Road. Follow directions below for **"From the corner of Wolf Road and 55th 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 47th Street, continuing to 55th Street. Follow directions below for **"From the corner of Wolf Road and 55th 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 47th Street, continuing to 55th Street.
Option B: From Wolf Rd southbound: Pass through Western Springs, continue to 55th Street.

Follow directions below for **"From the corner of Wolf Road and 55th Street**".

From the corner of Wolf Road and 55th 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