Allergy and Asthma Clinic (Adults and Children)

Cricklewood Center
1008 South Fifth Ave. Suite 201
Clarion, PA 16214

PH: 814-226-1599
FAX: 814-226-1583

90 Beaver Drive, Dubois, PA
1-800-860-8979

Patient Name: ______________________ DOB: __________ Age: _____ Sex: ________
Social Security#:________________ Phone#: ____________________
Address: ______________________________ City: ____________ State: ______ Zip:_______
Spouse Name (or Parent if minor):_____________________________

If minor, are parents: Married ❑ , Divorced ❑ , Separated ❑, Widowed ❑

Parent's address (If different from above):______________________________________
Responsible Party's Name: ________________________ Social Security #: _________________
Employer's Name & Address:_____________________________

May we contact you here: YES ❑ , NO ❑

Family Doctor's Name & Address: ____
Dentist's Name & Address: ____
Past Medical Problems: ____
Family Medical History: ____
Medications: ____
Known Drug Allergies: ____

Do you smoke? YES ❑ , NO ❑ If YES, how much:____________ How long? _____________

Does anyone who lives in the house smoke? YES ❑ , NO ❑

Is there a history of drug use? YES ❑ , NO ❑ If YES, how much:________ How long? __________

Do you ever drink alcoholic beverages? YES ❑ , NO ❑

Do you use a seat belt or car seat? YES ❑ , NO ❑

Do you have guns? YES ❑ , NO ❑ If YES, are they locked up? YES ❑ , NO ❑

How did you hear about us? ____
Whom shall we thank for your visit today? _____________________________________

In case of emergency, who may we contact regarding your medical condition?

1. Name: ________________________Phone#: ________________ Relationship: __________
2. Name: ________________________Phone#: ________________ Relationship: __________

* If you are planning on changing your insurance, please notify us in advance to make sure that we do participate with that insurance.

*** Pediatric Patients only ***

Mother's Name: ____ DOB: ______________
Father's Name: ____ DOB: ______________

Delivery: C-section ❑ , Vaginal ❑ Birth Weight: __________ Problems (if any): ______________

Breastfed ❑ , Bottle fed ❑ Formula Type: ____________________

Development: Sat alone:________Crawled: ________ Walked: ______Talked (sentences): _______

<u>OFFICE POLICIES</u>
To help serve you better in getting proper care.

1.) Our office hours are as follows:

Monday	8:30 A.M. – 5:00 P.M.
Tuesday	9:30 A.M. – 6:00 P.M.
Wednesday	8:30 A.M. – 5:00 P.M.
Thursday	9:30 A.M. – 6:00 P.M.
Friday	7:30 A.M. – 1:00 P.M. (Dubois Office)
	1:30 P.M. – 3:00 P.M. (Clarion Office)

Telephones will be turned off 1 hour prior to closing.

THE OFFICE WILL BE CLOSED DAILY FROM 12:30 P.M. – 1:30 P.M.

2.) For **true** emergency health conditions that <u>cannot wait until the office reopens, the following workday</u>, please call 1-888-743-2268. Highmark patients may call Blues on Call for questions or emergencies at 1-888-BLUE-428.

3.) Please bring your insurance card to the office with every visit and notify us of any changes in your name, address or phone number. **<u>If you are planning on changing your insurance, please notify us in advance to make sure that we do participate with that insurance.</u>**

4.) **<u>It is your responsibility to get any referrals</u>** that your insurance company requires prior to your appointment. If you did not get the referral, then you will be responsible for all the charges for that date of service.

5.) If your insurance company requires a copay for the office visit, it will be collected prior to the appointment or the patient may not see the physician. Copays not paid on the date of service will be charged an additional $10.00.

6.) If is advisable that you call your insurance company to see if immunizations are covered. If you find out that immunizations are not covered, you may wish to use the Well Baby Clinic for your child's immunizations (PH: 226-2170).

7.) Please notify the office 24 hours prior to the appointment date to cancel your appointment. **<u>Not showing up for three appointments may result in the patient being discharged from the practice.</u>** Prescriptions should be refilled at your appointment with the physician. Missed appointments, chart copies, extra forms or prescription refills not filled at your appointment, may involve an additional charge ranging from $5.00 to $30.00.

8.) Please no food or drink in the office.

Thanks you for your consideration.

Dr. H. I. Desai & Staff

Signature ____________________

H. I. Desai, M.D.
ALLERGY & ASTHMA CLINIC
OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fee with you at any time. Your clear understanding of our financial policy is important to our professional relationship; so, please ask if you have any questions about our fees, policies, or your responsibility.

<u>If you have no insurance, full payment is due at the time of service</u> unless other arrangements have been made prior to the date of service.

<u>If you have insurance</u>, we will help you receive maximum benefits; however, the following policies apply.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE FILE CLAIMS AS A COURTESY TO OUR PATIENTS. WE WILL NOT BECOME INVOLVED IN ANY DISCPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, SECONDARY CHARGES, USUAL AND CUSTOMARY CHARGES, ETC.
YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

THE PATIENT IS RESPONSIBLE TO FILE ANY SECONDARY, CO-INSURANCE, OR MAJOR MEDICAL CLAIMS.

Pennsylvania insurance law requires your insurance company to process these claims in 30 days; therefore, all uncovered charges or remaining balances on partially paid services are due within 60 days of the Explanation for any Medical Benefits.

1. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement for any claim.

2. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled.

3. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. <u>I understand that I am financially responsible for all charges whether or not they are paid by said insurance.</u>

Date	Signature
______________________	______________________

FINANCIAL RESPONSIBILITY WAIVER

I understand that if my insurance benefits do not fully cover the office visits and all procedures done at the Allergy & Asthma Clinic then I am FINANCIALLY RESPONSIBLE and AGREE TO PAY THE REMAINING BALANCE AND ALL CHARGES RELATED TO THE SERVICES.

I understand that the Allergy & Asthma Clinic (AAAC) as a **PCP** practice is presently closed to: Medical Assistance, all Chip insurances and other HMO's. I understand that if I acquire one of these insurances I may not be able to continue as a patient here for primary day to day care.

EFFECTIVE MARCH 1, 2005, THE ONLY STATE FUNDED INSURANCE THAT THE ALLERGY & ASTHMA CLINIC WILL BE PARTICIPATING WITH, **AS A PCP**, WILL BE MEDPLUS!!

AAAC as a SPECIALIST practice is open to most insurance plans.

Patient's Signature: ________________________ **Date:_______________________**

Witness Signature: ________________________ **Date:_______________________**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the acknowledgement and Concent

This acknowledgement of notice and consent authorizes Allergy & Asthma Clinic to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices. Allergy & Asthma Clinic has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail: Address to Allergy & Asthma Clinic, Attention: Privacy Officer, 1008 S.Fifth Ave., Cricklewood Center, Clarion, PA 16214
Telephone: 814-226-1599
Fax: 814-226-1583

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Allergy & Asthma Clinic. Allergy & Asthma Clinic is authorized to use and disclose health information about __________________________________ (Patient Name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

______________________________________ ______________________________________

Signature of the Patient Date
(Or Patient's personal representative)

Personal representative information (if applicable):

____

Name of Personal representative

____

Relationship to patient (or other authority)

Allergy and Asthma Clinic (Adults and Children)

ALLERGY QUESTIONNAIRE

NAME:_________________________ AGE:________________ REFERRED BY:_______________

* **Please answer all questions as completely and as accurately as possible.**
This information is very important in learning more about your allergies and how to control it.
If you are uncertain about the answer to a particular questions, please leave it blank.

**** Selection of testing material will depend on answers given here.***

ALLERGIC PROBLEMS: Kindly circle YES or NO.
Please underline symptoms below as they apply to you.

A) **EYES:** Have you ever had eye symptoms of itchiness, tearing, swelling and redness ? **----------------------YES** **NO**

B) **NOSE:** Have you ever had nasal symptoms of stuffiness, runny nose, itching, sneezing, snoring, nose bleeds, loss of smell sensation, rubbing nose, frequent morning sore throats, throat clearing ? **-----------------------------YES** **NO**

C) **SINUSITIS:** Do you suffer from frequent sinus infections? **---YES** **NO**

D) **EARS:** Have you ever had frequent ear infections, sensation of fullness in the ears or popping and crackling noises? **--YES** **NO**

E) **CHEST:** Have you ever had spells of coughing, wheezing, shortness of breath or chest tightness? **-------------YES** **NO**

F) **SKIN:** Have you ever had Eczema (dry, rough, red, itchy patches of skin)? **-----------------------------------YES** **NO**

Have you ever had hives (itchy, red, bumpy swellings)? **---YES** **NO**

G) **FOODS:** Following ingestion of foods, have you ever had symptoms like: hives or other rashes, stomach ache, diarrhea, vomiting or any breathing problems involving nose or lungs? **--YES** **NO**

H) **DRUGS:** Are you allergic to any drugs? **---YES** **NO**
(If yes, list the drugs and describe the reaction.)

I) **INSECTS:** Are you allergic to any insects? **---YES** **NO**
(Bees, Wasps, Yellowjackets etc. Describe the usual reaction):

J) **ALLERGIC REACTION:** Have you suffered from any allergic reactions? **---YES** **NO**
(If so, describe the reaction):

OTHER ASPECTS ABOUT YOUR ALLERGIES:

Do any of these items aggravate your allergic symptoms?
(Mark an "X" where applicable)

	Eyes	Nose	Chest	Eczema	Hives
Mold / Mildew					
Hay					
Animals					
Birds / Feathers					
Trees					
Grass					
Mowing Lawn					
Weeds					
Flowers					
Dust					
Perfumes					
Sprays					
Shaving Lotion					
Cosmetics					
Paint					
Smoke					
Cleaning Products					
Soaps / Detergents					
Exhaust Fumes					
Newspapers					
Weather Changes					
Exertion					
Excitement					
Tension					
Milk / Dairy Products					
Eggs					
Wheat					
Nuts					
Fish / Seafood					
Insects (bees etc.)					

Name ALL the **Drugs** you have taken:

- For your nose (Hay Fever)
- For Hives
- For Eczema
- For Eyes
- For Asthma
- Have you ever taken Prednisone or Cortisone for Asthma? ______________________________YES NO
- For any other illness?
- Have you taken any HERBAL REMEDIES for any illness? ______________________________YES NO
  (If so, please list them):

PAST HISTORY:

1. Have you ever smoked cigarettes ❑ , cigars ❑ or a pipe ❑? ____________________________YES NO
   How many per day? ____________________________ For how many years? ____________________________
2. Have you previously had skin (allergy) testing done? ____YES NO

   When: ________________________

   Name the doctor: ____________________
3. Have you ever been on allergy injections (shots)? ____YES NO

   When: ________________________

   Name the doctor: ____________________
4. When was the last time you had the following?

   Chest X-ray? ________________________

   Sinus X-ray? ________________________

   Breathing Test? ________________________
5. List other illness you may have had in the past and the dates:

FAMILY HISTORY:

Put an "X" in the appropriate box if any of your family members have had any of the following conditions:

	Asthma	Hayfever	Eczema	Hives	Food Allergy	Drug Allergy	Other Allergy
Father							
Mother							
Brother							
Sister							
Son							
Daughter							
Grandparents							
Uncles / Aunts							

PERSONAL DATA:

1. What is your occupation?____

   For how long? ____

   List other major occupations in the past:

2. At present, do you smoke cigarettes ❑ , cigars ❑ or a pipe❑? _____________________________YES NO
   If YES, how many per day?________________

3. What are your hobbies?

4. Do you frequently miss work or school because of your allergy or asthma symptoms? ______________YES NO
   If YES, when?

5. While on vacation were your allery symptoms better ❑, or the same ❑?

LQ H/o
Devl/Imm H/o

HOME ENVIRONMENT:

Check the box next to the appropriate answers.

1. **HOME IN GENERAL**

Location: Town ❑, Village ❑, Countryside ❑

Type: Single Family Dwelling ❑, Apartment ❑, Mobile Home ❑

How old is the home?____________________ Number of years lived there? ______________________

2. **BASEMENT (If present)**

Finished ❑, Unfinished ❑, Earth ❑ , Vapor barrier:________ YES NO

3. **HEATING**

Radiator ❑, Space Heater ❑, Fireplace ❑ , Wood ❑, Electric ❑,

Forced air : Oil ❑, Gas ❑

Filter : Disposable ❑, Permanent ❑ Frequency of Filter Change_____________

4. **AIR CONDITIONING**

Room Size❑, Central ❑, None ❑

5. **VACUUM CLEANER**

Central ❑, Canister ❑, Upright ❑ Bag ❑ Bagless ❑

6. **HUMIDIFIER**

Portable ❑, Central ❑, Vaporizer ❑, None❑

7. **MOISTURE AND MILDEW**

Condensation on walls or windows ?_________ YES NO

Mildew?________________________________ YES NO

Exhaust Fans in kitchen? __________________ YES NO

Exhaust Fans in bathroom? ________________ YES NO

Clothes Dryer?___________________________ YES NO Inside ❑, Outside❑

8. **BEDROOM**

Floor: Wood ❑, Tile ❑, Wall-To-Wall Carpet ❑, Area Rug ❑

Carpet: None ❑, Wool ❑, Synthetic ❑, Long Shag ❑, Short Shag ❑

Windows: Drapes❑, Washable Curtains❑, Shades ❑, Venetian Blinds❑

Bedding: Wool❑, Feathers ❑, Synthetic ❑, Cotton ❑

Mattress Cover: Cotton❑, Rubber ❑, Plastic ❑, None ❑

Pillows: Feather ❑, Slab Foam ❑, Chip Foam❑, Polyester❑, None❑

Items in the room: Books❑, Stuffed animals❑, Models❑, Dolls❑, Plants❑

Stored old clothes❑, Other stored items❑

9. **ANY EXPOSURE** to animals, birds, fish, smoke, mildew, feathers, etc. at home, school, work or friends? ___YES NO
If YES, please elaborate:

Are animals at home kept Indoors ❑, Outdoors❑

10. **SMOKERS** in the home (cigarettes, cigars, pipes): None ❑, Mother ❑, Father ❑, Other person ❑

11. **PLANTS**

Type: ______________________________

Number: ______________________________ Location: ______________________________

12. **FAMILY HOBBIES**

13. Cottage ❑, Camper ❑