

**PATIENT INFORMATION FORMS**

<b>1) PATIENT NAME:</b>			
FIRST	Middle	LAST	Suffix
<b>2) DATE OF BIRTH:</b>			
Month	Day	Year	Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE Social Security #:
<b>3) PATIENT HOME ADDRESS:</b>			
STREET	APARTMENT NUMBER	CITY	State ZIP CODE
<b>4) HOME TELEPHONE:</b>		<b>EMAIL:</b>	
CELL Phone Number:		Work Number:	
<b>5) Emergency Contact:</b>		Telephone Number Emergency Contact:	
<b>6) PRIMARY CARE PHYSICIAN:</b>		Physician Phone Number:	
<b>7) CONSULT REQUESTED BY:</b>			

**INSURANCE INFORMATION:**

Insurance SUBSCRIBER ⇨ ONLY if different from patient (for insurance purposes only):

<b>8) CARDHOLDER:</b>			
FIRST	Middle	LAST	Suffix
<b>9) DATE OF BIRTH:</b>			
MONTH	DAY	YEAR	Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE Social Security #:
<b>10) HOME ADDRESS (only if different from patient):</b>			
Street / Apt.	City	State	ZIP CODE
<b>11) HOME TELEPHONE:</b>		<b>Work Number:</b>	
Cell Phone Number:		Work Number:	
<b>12) SUBSCRIBER IS THE:</b> <i>Father Mother Son Daughter Wife Husband Self Other</i> OF THE PATIENT			
(PLEASE CIRCLE ONE OF THE ABOVE)			

Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. If you do not obtain a valid referral, and your insurance company requires one, then services are considered not-covered and you are responsible for payment. It is your responsibility to pay any co-payment and deductible amounts required by your insurance carrier. In order to control the cost of billing, we request that charges for office visits be paid at the conclusion of each visit.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans to the practice named on this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize your office to leave reminder messages on my voice mail/answering machine.

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SIGNED (patients over 18/ parent or guardian)

-----  
DATE

-----  
NAME (please print)

**ADVANCED ALLERGY & ASTHMA ASSOCIATES, P.C. FINANCIAL POLICY**

We are doing everything possible to hold down the cost of medical care. You can help by eliminating the need for us to bill you. The following is a summary of our financial policy:

Patients are responsible for all office charges not covered by their insurance such as co-insurance, deductibles and co-payments. **Co-payments are due at the time of service according to the terms of your insurance company.**

Patients receiving allergy injections are expected to make their co-payment at the time the injection is given. This significantly reduces billing costs.

If your insurance plan requires, you must contact your Primary Care Physician to obtain a **referral** prior to your visit. Obtaining these referrals is your responsibility and we cannot provide service to you without them.

As a courtesy we will bill you for co-insurances and deductibles after we have heard back from your insurance. We urge our patients to call their member services to see if their policy has deductibles, co-insurance or co-payments for our services. Your plan may have these additional costs to keep premiums down. If you have another visit and there is a prior balance due, you will be asked to pay it at that time

Payments may be made by cash, check, money order or credit card. We accept MasterCard, Visa & American Express. Patients with an outstanding balance of 60 days will be asked to speak with our Billing Department prior to scheduling an appointment.

Unpaid balances are billed monthly. We use computer billing and are aware that sometimes errors do occur. Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill or are unable to pay on the day you are to be seen, please explain the situation to us. Satisfactory arrangements can almost always be made. We strive to remain flexible and understanding of individual circumstances, and will do our best to help. Financial considerations should never prevent you from receiving the care you need at the time you need it.

Effective immediately our office has instituted a **\$75 fee for missed appointments.** This has been made necessary by increasing numbers of people not keeping their appointments or failing to notify us of a cancellation 24 hours in advance of their appointment time. A cancelled or rescheduled appointment allows us to bring in a patient who may be on a waiting list trying to urgently see the doctor. We appreciate your understanding in helping us provide you with the best care we can.

*I the undersigned understand this financial responsibility as stated above.*

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

**Print name:** \_\_\_\_\_ **Patient Name (if minor):** \_\_\_\_\_

# ADVANCED ALLERGY & ASTHMA ASSOCIATES, P.C.

Adult & Pediatric Allergy & Asthma

STEVEN J. SIMONTE, M.D.

Diplomate, American Board of Allergy & Immunology

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New York, NY 10007

## PATIENT ALLERGY HISTORY FORM

PATIENT NAME: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

CONSULT REQUESTED BY: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

### WHAT IS THE MAJOR REASON(S) FOR THIS ALLERGY/ASTHMA CONSULTATION?

PLEASE DESCRIBE: \_\_\_\_\_

### ★ COMPLETE THE FOLLOWING SECTION IF THERE IS A HISTORY OF NASAL, SINUS, EYE or EAR SYMPTOMS ★

**CIRCLE** any of the following if they apply to you: *NONE*

*Nasal stuffiness/congestion*      *Sneezing*      *Post Nasal Drip*      *Itchy Nose*      *Itchy Eyes*      *Watery Eyes*

*Ear problems*      *Headache*      *Sinus Pressure*      *Circles under the eyes*      *Other:* \_\_\_\_\_

**Nasal Discharge/Runny Nose:**      *NONE*      *Clear*      *White*      *Yellow*      *Green*

**WHEN** are you **SYMPTOMATIC**?      *SPRING*      *SUMMER*      *FALL*      *WINTER*      *YEAR-ROUND*

**WHEN** are your symptoms the **WORST**?      *SPRING*      *SUMMER*      *FALL*      *WINTER*      *YEAR-ROUND*

**HOW LONG** have you had your symptoms? \_\_\_\_\_

**WHAT ALLERGY MEDICATIONS** (antihistamines/nasal sprays/eye drops/decongestants) **HAVE YOU TAKEN & HOW EFFECTIVE WERE THEY?**

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

**SUSPECTED** or **KNOWN CAUSES** of these symptoms (please circle all that apply):

*Dust*      *Trees*      *Grass*      *Weeds*      *Mold*      *Dogs / Cats*      *Latex*      *Cigarette Smoke*

*Foods*      *Odors/Fumes*      *Perfume*      *Mowing Lawn*      *Cold Weather*      *Spicy foods*      *Alcohol*      *Other:* \_\_\_\_\_

Number of **SINUS** Infections treated in the Past Year: \_\_\_\_\_ *NONE*

Number of **EAR** Infections treated in the Past Year: \_\_\_\_\_ *NONE*

Last Antibiotic used for Sinus or Ear Infections (**NAME of DRUG & DATE of USE**): \_\_\_\_\_

Have you had a **Sinus X-RAY**?      *YES*      *NO*      Date(s): \_\_\_\_\_

Have you had a **Sinus CAT SCAN**?      *YES*      *NO*      Date(s): \_\_\_\_\_

Have you had **SINUS SURGERY**?      *YES*      *NO*      Date(s): \_\_\_\_\_

History of **NASAL POLYPS**?      *YES*      *NO*      Date(s): \_\_\_\_\_

History of **EAR TUBES**?      *YES*      *NO*      Date(s): \_\_\_\_\_

Do you wear **CONTACT LENSES**?      *YES*      *NO*

History of **Enlarged Tonsils/Adenoids**?      *YES*      *NO*

Have you had **Tonsils/Adenoids Surgically Removed**?      *YES*      *NO*      Date: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Advanced Allergy & Asthma Associates, P.C.

★ **COMPLETE THE FOLLOWING SECTION IF THERE IS A HISTORY OF ASTHMA, WHEEZING, OR COUGH** ★

NOT APPLICABLE (NO history of breathing or respiratory symptoms)

DATE Breathing Symptoms First Started: \_\_\_\_\_

**DESCRIPTION of SYMPTOMS** (please circle all that apply):  

DRY COUGH	WET COUGH	WHEEZING	SHORTNESS OF BREATH
CHEST TIGHTNESS	TIGHTNESS IN THROAT	SPUTUM/ PHLEGM (please circle sputum color: CLEAR WHITE YELLOW GREEN)	
WORSE AT NIGHT	WORSE DURING THE DAY	PROBLEM DURING THE DAY & NIGHT	

Frequency of **DAY** time SYMPTOMS: LESS THAN 2 DAYS A WEEK 3 OR MORE DAYS A WEEK EVERY DAY CONTINUAL

Frequency of **NIGHT** time SYMPTOMS: LESS THAN 2 NIGHTS/MONTH > 2 NIGHTS/MONTH > 1 NIGHT/WEEK FREQUENT

When are you **SYMPTOMATIC**? SPRING SUMMER FALL WINTER YEAR-ROUND

Any **EMERGENCY** Room Visits for Asthma/Breathing Problems: NONE 1-2 3-5 >5 Date(s): \_\_\_\_\_

**HOSPITALIZATIONS** for Asthma/Breathing Problems: NONE 1-2 3-5 >5 Date(s): \_\_\_\_\_

If hospitalized for asthma, were you ever admitted to an **Intensive Care Unit (ICU)**: NO YES Date(s): \_\_\_\_\_

How many times in the **past year** have you been on **ORAL STEROIDS** (Prednisone, Orapred, etc.) for Asthma? \_\_\_\_\_ NONE

Please list the **ASTHMA MEDICATIONS** that you are taking/have taken: NONE

**SUSPECTED** or known **TRIGGERS** of **ASTHMA/Respiratory Symptoms** (please circle all that apply):

Dust Trees Grass Weeds Mold Dogs / Cats / Animals Exercise Cigarette Smoke  
Colds/Infections Odors/Fumes Perfume Weather Changes Emotions/Stress Mowing Lawn Reflux/Heartburn  
Foods Cold Air Humidity Pollution Other: \_\_\_\_\_

Previous History of **PNEUMONIA**? YES NO Number of Episodes: \_\_\_\_\_ Date(s): \_\_\_\_\_

Previous History of **BRONCHITIS**? YES NO Number of Episodes: \_\_\_\_\_ Date(s): \_\_\_\_\_

Last **ANTIBIOTIC** used for Pneumonia or Bronchitis (name of drug & date of use): \_\_\_\_\_

Have you had a **CHEST X-RAY**? YES NO Date(s) of Chest X-Ray: \_\_\_\_\_

Have you had a **CHEST CT/CAT SCAN**? YES NO Date(s) of Chest CT/CAT Scan: \_\_\_\_\_

★ **COMPLETE THE FOLLOWING SECTION IF THERE IS A HISTORY OF SKIN PROBLEMS/RASH/ECZEMA** ★

NONE ECZEMA HIVES SWELLING CONTACT RASH Other: \_\_\_\_\_

Approximate DATE when symptoms first started: \_\_\_\_\_ Known or suspected CAUSES of rash: \_\_\_\_\_

**DID ANY OF THE FOLLOWING OCCUR AROUND THE TIME OF ONSET OF THE RASH** (please circle all that apply)?

Foreign travel Change in Medications Infection/Cold/Flu Change in Cosmetics Exposure to Animals Exposure to Latex  
Change in Detergents Diarrheal Illness Course of Antibiotics Change in Soap, Shampoo, etc. Change in Diet  
Change in Home/ Work Environment Insect Sting/Tick Bite New Clothing/Jewelry Other: \_\_\_\_\_

PLEASE list any **MOISTURIZERS** or **SKIN MEDICATIONS** that you are currently using: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

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★ **HAVE YOU HAD ANY REACTIONS TO BEE/INSECT STINGS?** (please circle): *NONE* *NEVER STUNG*

*LOCAL REACTION/SWELLING AT STING SITE* *HIVES / RASH* *DIZZINESS / THROAT TIGHTNESS / BREATHING PROBLEMS* *ANAPHYLAXIS*

★ **HAVE YOU HAD ANY PREVIOUS ALLERGY TESTING?** *NO* *YES*

If **YES**: Date: \_\_\_\_\_ Testing was **POSITIVE** to: \_\_\_\_\_

Have you ever been on **ALLERGY INJECTIONS** (please circle): *NO* *YES* Name of previous Allergist: \_\_\_\_\_

Previous Injection Dates: \_\_\_\_\_ Date of Last Injection: \_\_\_\_\_

★ **HAVE YOU HAD ANY ALLERGIC REACTIONS to FOODS?** *NO* *YES*

If **YES**, please list **DATE OF REACTION, FOOD INVOLVED & SYMPTOMS EXPERIENCED**:

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

★ **PAST MEDICAL HISTORY:** List all Medical Conditions: *NONE*

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

List any Emergency Room visits, Hospitalizations, & Surgeries: *NONE*

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

For **WOMEN** only: Are you pregnant? *NO* *YES* Are you planning to become pregnant in the next year? *NO* *YES*

Please **CIRCLE** any additional problems that you are experiencing:

*Depression / Anxiety* *Fatigue* *Visual Changes* *Hearing Problems* *Throat Problems* *Breathing Problems / Emphysema / COPD*  
*Chest Pain / Palpitations* *High Blood Pressure* *High Cholesterol* *Diabetes* *Rash / Itching* *Thyroid Problems* *Seizures* *Colitis*  
*Bladder Problems* *Muscles Aches* *Joint Pains* *Heartburn/Reflux* *Bleeding / Clotting Problems* *Hormone Problems* *Weight Change*

★ LIST ANY **MEDICATIONS** taken in the past week (include Aspirin/Vitamins/Over-The-Counter medications): *NONE*

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

★ HAVE YOU EVER HAD ANY **ALLERGIC REACTIONS to MEDICATIONS and/or IV CONTRAST?** *NO* *YES*

If **YES**, please list **DATE OF REACTION, DRUG INVOLVED, & SYMPTOMS EXPERIENCED**:

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

★ **IMMUNIZATION HISTORY:** Are you (or your child's) immunizations up to date? *NO* *YES*

Have you (or your child) ever had a chicken pox infection (varicella) or received the vaccine for chicken pox? *NO* *YES*

Have you (or your child) ever had a reaction after receiving an immunization? *NO* *YES* If **YES**, please describe the reaction below:

\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

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★ **SOCIAL HISTORY:** MARITAL STATUS (patient or parents if minor): *Single Married / Domestic Partner Divorced Widowed*

Children, or siblings if minor: \_\_\_\_\_

**SMOKING** history: *NEVER CURRENT PAST* Packs Per Day: \_\_\_\_\_ For How Long: \_\_\_\_\_ When Did You Quit: \_\_\_\_\_

Drug/Alcohol Use: \_\_\_\_\_

★ **FAMILY MEDICAL HISTORY:** Enter age & **circle below** if family members have a significant history for any of the following:

**MOTHER** Age: \_\_\_\_\_ *ASTHMA ECZEMA FOOD ALLERGY HAY FEVER/ ENVIRONMENTAL ALLERGIES* Other: \_\_\_\_\_

**FATHER** Age: \_\_\_\_\_ *ASTHMA ECZEMA FOOD ALLERGY HAY FEVER/ ENVIRONMENTAL ALLERGIES* Other: \_\_\_\_\_

**BROTHERS** Age(s): \_\_\_\_\_ *ASTHMA ECZEMA FOOD ALLERGY HAY FEVER/ ENVIRONMENTAL ALLERGIES* Other: \_\_\_\_\_

**SISTERS** Age(s): \_\_\_\_\_ *ASTHMA ECZEMA FOOD ALLERGY HAY FEVER/ ENVIRONMENTAL ALLERGIES* Other: \_\_\_\_\_

**SONS** Age(s): \_\_\_\_\_ *ASTHMA ECZEMA FOOD ALLERGY HAY FEVER/ ENVIRONMENTAL ALLERGIES* Other: \_\_\_\_\_

**DAUGHTERS** Age(s): \_\_\_\_\_ *ASTHMA ECZEMA FOOD ALLERGY HAY FEVER/ ENVIRONMENTAL ALLERGIES* Other: \_\_\_\_\_

★ **ENVIRONMENTAL HISTORY:**

List **ALL SMOKERS** who live in the home \_\_\_\_\_

List **ALL ANIMALS** in or around the home \_\_\_\_\_

How long have animals been in or around the home? \_\_\_\_\_ Pets allowed in the bedroom? *YES NO*

Any problems with **PEST INFESTATION?** *NONE Cockroach Mouse Rat* Other: \_\_\_\_\_

**DWELLING TYPE:** *Apartment Loft Townhouse House Basement Apartment*

**Age of Building:** \_\_\_\_\_ **How long have you lived there?** \_\_\_\_\_

**Heating System:** *Radiator Forced Hot Air Baseboard Wood Burning Stove* Other: \_\_\_\_\_

**Air Conditioning:** *NONE Window Central*

**Floor Covering:** *Wood Floor Area Rug Wall to Wall Carpet Carpet over Cement* Other: \_\_\_\_\_

**Air Filter/Cleaner:** *NONE Room Central* **Are you using a HEPA Air Filter or HEPA Air Cleaner?** *YES NO*

**Basement:** *NONE Unfinished Finished History of Water Leakage Damp Dry Musty / Visible Mold*

**Bedroom:** Winter bedroom temperature: \_\_\_\_\_ **Are you using Allergy Covers/Dust Mite Encasings?** *YES NO*

Type of Pillow: *Synthetic Feather*

Bedding: *Feather Bed Feather Comforter*

Description of Bedroom: *Neat Cluttered Dusty Stuffed Toys  
Curtains Drapes Blinds Window Shades Upholstered Furniture*

★ **OCCUPATIONAL EXPOSURES:**

Please describe **TYPE OF WORK OR DAILY ACTIVITY:** \_\_\_\_\_

Please circle: *Office Setting Outdoor Setting Homemaker Pre-School School (Grade \_\_\_\_/College Student)*

Are symptoms affected by work or school? \_\_\_\_\_

Please inform the physician of any additional history or problems you are experiencing.  
Thank you for your time in filling out these forms.

**ADVANCED ALLERGY & ASTHMA ASSOCIATES, P.C.**

305 Broadway-Suite 525  
New York, NY 10007

**Steven J. Simonte, M.D.**

Diplomate American Board of Allergy & Immunology

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

HIPPA Compliance Officer: Steven J. Simonte, M.D.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization's Privacy officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I also understand that you are not required to agree to my requested restrictions, but if you do agree, than you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (**PLEASE PRINT**) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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***For office use only:***

Signed form received by: \_\_\_\_\_

Acknowledgement refused:

Efforts to obtain: \_\_\_\_\_

Reason for refusal: \_\_\_\_\_

\_\_\_\_\_