HAMILTON ALLERGY, ASTHMA AND SINUS CENTER, P.A.

PATIENT QUESTIONNAIRE - ***Please fill as completely as possible***

Name _____ **Age** _____ **Today's Date** _____

Rea son for visit: _____

_____

_____

***Please list current prescription and non-prescription medications (also list herbals, supplements, etc*):**

_____ _____

_____ _____

_____ _____

_____ _____

*** *When was the last time you took any antihistamine, cough/cold medicine or Singulair:* _____

PAST MEDICAL HISTORY - ***Check the box for either "Yes" ,"No" or "Not sure" for each condition:***

Condition	Yes	No	Unsure	Condition	Yes	No	Unsure	Condition	Yes	No	Unsure
Stroke	☐	☐	☐	Epilepsy	☐	☐	☐	Goiter	☐	☐	☐
Meningitis	☐	☐	☐	Seizures	☐	☐	☐	Lyme Disease	☐	☐	☐
Cataracts	☐	☐	☐	Glaucoma	☐	☐	☐	Hepatitis	☐	☐	☐
Wear contact Lenses	☐	☐	☐	Nasal Surgery	☐	☐	☐	Diabetes	☐	☐	☐
Tonsillectomy	☐	☐	☐	Adenoidectomy	☒	☐	☐	Hives	☐	☐	☐
Myringotomy-ear tubes	☐	☐	☐	Vertigo	☐	☐	☐	Eczema	☐	☐	☐
Meniere's Disease	☐	☐	☐	Asthma	☐	☐	☐	Psoriasis	☐	☐	☐
Emphysema	☐	☐	☐	Bronchitis	☐	☐	☐	Dry skin	☐	☐	☐
Hypertension	☐	☐	☐	Heart Disease	☐	☐	☐	Depression	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐	Palpitations	☐	☐	☐	Anxiety	☐	☐	☐
Reflux or Heartburn	☐	☐	☐	Ulcer	☐	☐	☐	Stress	☐	☐	☐
Myocardial Infarction	☐	☐	☐	Kidney Stone	☐	☐	☐	Bladder Condition	☐	☐	☐
Hysterectomy	☐	☐	☐	Prostate Condition	☐	☐	☐	Arthritis	☐	☐	☐
Hyperthyroidism	☐	☐	☐								

Any other conditions not listed above: _____

RECENT MEDICAL HISTORY

How times in the past 12 months have you had the following?

Ear Infections _____ Sinus Infections _____ Bronchitis _____ Pneumonia _____

Have you been hospitalized in past 12 months? ☐ Yes ☐ No *If yes, why and when?* _____

_____

PAST SURGICAL HISTORY: *Have you had any surgical procedures*? ☐ Yes ☐ No

If yes, why and when? _____

_____

IMMUNIZATION HISTORY *Are your immunizations up to date*? ☐ Yes ☐ No

PAST ALLERGY HISTORY *Please describe previous reactions, name the substance and describe what happened*:

Drug Reactions? _____ ☐ No past drug reactions

Food Reactions? _____ ☐ No past food reactions

Do you have allergies to any of the following? ☐ Insect bites ☐ Bee stings ☐ Latex ☐ None

Please turn over page and complete other side as well.

BIRTH HISTORY *(for patients under 18 years old)*

Patient was born ☐ Full term ☐ Premature (at ___ months gestation)

After birth patient: ☐ left hospital routinely ☐ was placed in incubator (for ___ days) ☐ needed breathing machines

Patient's growth/weight has been: ☐ normal for his age ☐ reduced for age but following curve ☐ not following curve

PAST ALLERGY EVALUATION

Have you had allergy testing? ☐ Yes ☐ No

If yes, what kind? ☐ Skin tests ☐ Blood tests ☐ Other

When? _____ *Who did the tests?* _____

What were you sensitive to? ☐ Ragweed ☐ Grass ☐ Dust ☐ Mold ☐ Trees ☐ Cat ☐ Dog ☐ Foods ☐ Unsure

Did you receive allergy shots? ☐ Yes ☐ No *If yes, did they help?* ☐ Yes ☐ No ☐ Not sure

If you have had allergy shots, when did you start and how long were you on them? _____

FAMILY HISTORY

Do you have family members with allergies, asthma, eczema or hives? ☐ Yes ☐ No

If yes, *which family members have which condition*? _____

_____

ENVIRONMENTAL HISTORY

What type of building do you live in? ☐ House ☐ Apartment ☐ Townhouse *How old is the building?* _____ *years*

Type of heat? ☐ Forced air ☐ Radiator ☐ Baseboard ☐ Fireplace/woodstove *Airconditioning?* ☐ None ☐ Window ☐ Central

Any air filtration systems? ☐ Portable HEPA units ☐ Portable ionic system ☐ HEPA vacuum ☐ HEPA filter in HVAC

Do you have dust mite/allergy-proof covers on your bed? ☐ Yes ☐ No

PETS - *Do you have any furry pets at home*? ☐ Yes ☐ No

Please list the types of furry pets, number of each, and how long you have had them: _____

_____

Did the previous residents have pets? ☐ Yes ☐ No If yes, what and when? _____

Do you have regular exposure to pets at friends or relatives? ☐ Yes ☐ No

If yes, What? ☐ Dog ☐ Cat ☐ Bird Other _____ How often? _____

SOCIAL

Do you smoke? ☐ Never I quit --> How many years ago did you quit? ____ ☐ Current smoker

At the most, how much do you (or did you) smoke? ____ pack per day. For how many years? ____

Does anyone smoke in or around the home? ☐ Yes ☐ No If yes, who and where? _____

Do you use recreational drugs? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No *If yes, how often?* ☐ Daily ☐ Weekly ☐ Social ☐ Rarely

EXPOSURE

If patient is a child, do they regularly go to ☐ Daycare ☐ Preschool ☐ School ☐ Babysitter's house ☐ Home only

Number of children in the home _____ *List their ages* _____ _____ _____ _____ _____ _____

WORK ENVIRONMENT

Occupation _____ *Location* ☐ School ☐ Factory ☐ Outdoors *Others* _____

Select any substances which you are regularly exposed to at work:

☐ Chemical fumes ☐ Odors ☐ Smoke ☐ Molds ☐ Pet dander ☐ Dust ☐ Pollen *Others* _____

Hamilton Allergy Asthma & Sinus Center, PA - Aslam Lateef, MD

EMAIL:

REGISTRATION SHEET - PATIENTS UNDER 18 YEARS

BLACK INK ONLY & PRINT CLEARLY (fill in as much as possible) ***GRAY ITEMS MUST BE COMPLETED.***

Patient's First Name _____ **Mid Initials** _____ **Last Name** _____

Patient's Street Address _____ **City** _____ **State** ___ **Zip** _____

Patient's Gender ☐ Male ☐ Female **Date of Birth** _____

Guardian / Responsible Party: First Name _____ **MI** _____ **Last Name** _____

Home Phone _____ **Cell** _____ ☐ No Cell # **Work** _____ ☐ No work #

Guardian's Date of Birth _____ **Marital Status** _____ **Social Security No.** _____

Relationship to Patient ☐ Mother ☐ Father ☐ Legal guardian Other _____

Guardian's Employer _____ **City** _____ **State** ___ **Zip** _____ ☐ Not Employed

Name of Emergency Contact _____ **Relation** _____ **Phone #** _____

How did you hear about us? ☐ Physician ☐ Friend / Family (Giive name _____) ☐ Insurance

☐ Internet search ☐ News Paper ☐ Yellow Pages ☐ Other - Explain _____

Did a medical provider gave a referal or recommended that you see an allergist? ☐ Yes ☐ No

If "YES", then fill items below

Recommending Provider First Name: _____ Last Name: _____

Recommending Provider's Street _____ City _____ State ___ Zip _____

Patient's Primary Care Doctor First Name: _____ Last Name: _____

Primary Care's Address Street _____ City _____ State ___ Zip _____

INSURANCE INFORMATION

Primary Insurance

Name of Company _____

Insurance ID # _____ **Insurance Group #** _____ **Co Pay $** _____

Subscriber's First Name _____ **Mid Initials** _____ **Last Name** _____

Subscriber' s Date of Birth _____ **Social Security No.** _____

Subscriber's Address Street _____ City _____ State ___ Zip _____

Subscriber's Relationship to Patient ☐ Mother ☐ Father ☐ Legal guardian ☐ Self Other _____

Secondary Insurance ☐ **No Secondary Insurance**

Name of Company _____

Insurance ID # _____ **Insurance Group #** _____ **Co Pay $** _____

Subscriber's First Name _____ **Mid Initials** _____ **Last Name** _____

Subscriber' s Date of Birth _____ **Social Security No.** _____

Subscriber's Address Street _____ City _____ State ___ Zip _____

Subscriber's Relationship to Patient ☐ Mother ☐ Father ☐ Legal guardian ☐ Self Other _____

Any other insurances? _____

For Office Use Only : *Date* _____ */ Init* _____

***** FLIP PAGE TO COMPLETE OTHER SIDE *****

AUTHORIZATION AND RELEASE

BLACK INK ONLY - GRAY ITEMS MUST BE COMPLETED

I acknowledge that I have reviewed the "Notice of Health Information Practice" as prominently displayed in waiting room.

Initials here _____

I certify that the information I have provided on "Registration Sheet" form is correct. I authorize the release of any medical or other information necessary in the processing of insurance claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims.

If my insurance requires referrals, I understand that it is my responsibility to obtain from my primary care doctor a valid referral before the time of visit with Dr. Lateef (preferably at least 72 hours before the visit). I understand that if an incorrect, incomplete or absent referral results in refusal of payment by my insurance company, I will be fully responsible for cost of services provided.

Signature _____ Date _____

(Signature of insured or authorized person/patient or parent if minor)

HAMILTON ALLERGY, ASTHMA & SINUS CENTER

Aslam Lateef, M.D., F.A.C.A.A.I., Board Certified in Allergy/Immunology

Pediatric and Adult Allergy, Clinical Immunology and Associated Pulmonary Diseases

2333 Whitehorse-Mercerville Road, Suite G • Mercerville Professional Park • Hamilton, NJ 08619 • 609-584-9200 (main) • 609-584-9299 (fax)

CONSENT FOR STANDARD SKIN TESTING

I, _____ , the (patient) or (parent/guardian) of_____
desire to undergo the following procedure:

Allergy Skin Testing (Prick/Scratch Testing)

_____

Name of Procedure

Purpose: To identify allergic triggers that may be related to my complaints.

The procedure has been explained to me. **Most common side effects include mild, temporary discomfort, local swelling, and mild to moderate itching at testing sites that may persist for several days. For most persons, discomfort and itch last for minutes to a few hours and swelling lasts between 1-3 days.**

More serious reactions are extremely rare and may include the following: itchy eyes, nose or throat; stuffy nose; runny nose; tightness in the throat or chest; coughing; wheezing; lightheadedness/faintness; nausea and vomiting; hives and generalized itching. Reactions more serious than this are extraordinarily rare but have been reported.

While serious reactions are extremely rare, I understand they are possible. I understand that precautions consistent with the best medical practice will be carried out to prevent and, if necessary, treat such reactions.

I have been provided the opportunity to ask questions regarding this procedure.

ADULT PATIENTS:

_____ _____

Signature of Patient (18 years of age or older) **Date**

IF PATIENT IS A CHILD:

_____ _____ _____

Signature of Parent or Authorized Consenting Party **Relationship to Patient** **Date**

(SPACE BELOW FOR OFFICE USE ONLY)

I certify that I was present and heard the oral presentation to the patient and/or authorized consenting party of the information contained in this consent and that it appeared to me that the signer understood the nature, risks and benefits of the proposed treatment and that I witnessed the above signature to this authorization.

_____ _____

Signature of Witness Date

_____ _____

ADVANCED ALLERGY, ASTHMA & SINUS CENTER

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **Advanced Allergy, Asthma & Sinus Center** for your medical care. We are committed to providing excellent medical care.
** PLEASE **read and sign** this form to acknowledge understanding of our patient financial policies.

Patient Financial Responsibilities
The patient (or the patient's guardian, if patient is a minor) is ultimately responsible for payment of ALL treatment and care.

We will assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

You will be asked to verify your information – this means showing a driver's license and insurance card at EVERY VISIT. Please inform us of any demographic and insurance changes immediately. If your insurance has changed, or you have more than one policy, please inform us and provide ALL insurance cards.

Patients are responsible for payment of co-pays, co-insurance, and deductibles. They are also ultimately responsible for payment for all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service, or immediately thereafter. For your convenience, we accept cash, check, and most major credit cards at our office.

There are often balances remaining after insurance company's payment, such as co-insurance and deductibles. We will send a statement to your billing address notifying you of any balances due. Any unpaid balance is the patient's (or guardian's) responsibility and payment in full is due immediately upon receipt of ANY statement from our office. Payment not made within 30 days of the statement issue date is deemed past due. Payment not received within 60 days of statement date will be sent to a collection agency.

If you are unable to pay the balance due in full, contact our billing office to discuss payment options.

Patient Authorizations

By my signature below, I hereby authorize assignment of financial benefits directly to **Advanced Allergy, Asthma & Sinus Center** and any associated healthcare entities for services rendered as allowable under standard third party contracts**. I understand that I am financially responsible for charges not covered by this assignment.**

By my signature below, I authorize **Advanced Allergy, Asthma & Sinus Center** personnel to communicate protected health information by mail or answering machine message, at locations and numbers which I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN DATE

_____
NAME