ALLERGY CARE, PLLC
2206 Genesee Street, Suite 101
Utica, NY 13502
Telephone: 315-624-7911 Fax: 315-624-7912

PATIENT APPOINTMENT GUIDELINES

Dear ____________________________________

Welcome to Allergy Care! An appointment has been scheduled for you at our office in Suite 101, ______________ at ________ a.m./p.m. The time for your evaluation has been exclusively reserved for you.

You may be charged $100 – initial consultation and $50 follow up appointment if you fail to show up or fail to give us a minimum of one full business days' notice of any changes to your appointment.

Please plan to be in our office for approximately 3 hours. Your initial evaluation is very extensive. Please DO NOT schedule other important events for the same day. If there is a problem, please call our office (315-624-7911 Option 1). Due to the unpredictable nature of allergies, follow-up appointments may take longer than expected if an emergency arises.

Please fill out the entire enclosed **PATIENT HISTORY** packet and bring it with you to your appointment. **Any form that is incomplete may cause a further delay in your visit.** If you have questions when completing this form, please call our office to speak with a Nurse.

We hope that the following directions and requests will be of help to you and will assist us in your care. We respect your time and we would like to make your visit to our office as efficient as possible.

MEDICAL/INSURANCE INFORMATION: At the time of your appointment please be sure to bring the following items or information with you and follow the guidelines given for medications.

Bring with you:
- **List of medications** you are presently taking (prescription or over-the-counter).
- Appropriate **Insurance cards**, Military ID, etc.
- **Photo ID** with current address.
- **Any co-pays or deposit, which ever you have been instructed to bring.**
- **Copies of any pertinent office visits, notes or information that may be important to your visit.**

Guidelines:
- Discontinue use of all antihistamines (see below), prescription and over-the-counter, **3 days** prior to your appointment if permitted by your primary care physician, who can contact us if he/she has any questions in this regard.

  The list of antihistamines include: **Alavert, Allegra, cetirizine, Antivert, Atarax, Benadryl, Benadryl Allergy, Bonine, brompheniramine, carbinoxamine, Levocetirizine, Children's Claritin/Zyrtec Allergy/Zyrtec Hives, Chlor-Trimeton, chlorpheniramine, Clarinex, Clarinex Reditabs, Claritin, Claritin Reditab, clemastine, cyproheptadine, dexchlorpheniramine, dimenhydriante, doxylamine, Dramamine, Dramamine Less Drowsy, fexofenadine, hydroxyzine, loratadine, meclizine, Palgic, Periactin, Tavist Allergy, Tripohist, Vistaril, Xyzal, and Zyrtec Allergy.**
  Patanol, Pataday, Optivar, Zaditor, & Elestat Eye Drops; and **Astelin, Astepro, Dymista & Patanase Nasal Sprays** are included in the antihistamines to be **discontinued**.

- Consult our office with regard to questions about prescription or OTC antihistamines/cold medications.
- **ALL OTHER inhalers & medications prescribed by your physician should be continued.**
- If you are unsure regarding any medication, contact your pharmacist or our office.

ALL PATIENTS:

1. No food or drink is permitted in the office during the visit. Bottled water is okay.
2. Do not wear perfume, cologne, hair spray or fragrant lotions to the visit.
3. **Please do not bring young children** (unless the child is the patient), friends or relatives to the appointment since our waiting room space is limited.
4. If the patient is a child, please be certain to give your child breakfast or lunch prior to the appointment unless specifically told not to do so.
5. A parent or legal guardian must accompany patients that are under the age of 18, live at home, and are a dependent, for the duration of the visit in order to be seen.
6. Patients who are 18 years and older, in college, and are a dependent, may be seen without a parent or legal guardian. However, if the patient is coming alone, please contact our office for further guidance **prior to appointment**.

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RECORDS RELEASE AUTHORIZATION

I hereby authorize :

ALLERGY CARE, PLLC

2206 Genesee Street, Suite 101

Utica, NY 13502

To release my record to: ____

____

The complete history of records in your possession, concerning my illness and/or treatment during the period from ____________________to_____________________.

NAME:____DATE:_________________________

SIGNATURE:____

WITNESS:____

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INSURANCE AUTHORIZATION STATEMENT

I hereby authorize Allergy Care PLLC and providers of ancillary services, to apply for benefits on my behalf for covered services rendered by him or at his request.
I request payment in turn from my insurance(s) as follows:

Primary Insurance Carrier: ___________________CARD HOLDER: __________________________
ID#________________________ Group#________________

Secondary Insurance Carrier: __________________CARD HOLDER: _________________________
ID#________________________ Group#________________

Tertiary Insurance Carrier: __________________CARD HOLDER: ___________________________
ID#________________________ Group#________________

To be made to the above provider and/or providers of ancillary services. I certify that the information I have provided regarding my insurance is accurate. I further authorize the release of any/all necessary medical information required to obtain any benefits to which I am entitled from the above listed insurances.

By signing this release I give you permission to speak to me or said card holder regarding my insurance coverage.

This authorization may be revoked by either my or the card holder at any time. I understand this must be submitted in writing.

Patient Name: _________________________

Signature: ______________________________ **Date: ____________________**
Patient, Guardian, Subscriber

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________________________, understand that as part of my health care, ALLERGY CARE, PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information, uses, and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that ALLERGY CARE, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ALLERGY CARE, PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. If ALLERGY CARE, PLLC changes their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

(over)

I wish the following family members, other individuals or organizations to have access to my health information:

____

____

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

______________________________ ______________________

Patient's/Responsible Party's Signature Relationship to Patient

____

Date

FOR OFFICE USE ONLY

[ ] Consent received by ______________________________ on ____________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on ____________________.

ALLERGY CARE, PLLC
Ludwig Edward Khoury, MD FAAAAI
Alyssia Lloyd, FNP
Roseanne Brindisi, FNP
2206 Genesee St. Suite 101
Utica, NY 13502
Telephone: 315-624-7911 / 315-624-7912

CONSULTATION / NEW PATIENT EVALUATION **DATE OF SERVICE:** ____________

Patient Name: ____ **DOB:** __________
First *Last* *MI* *MM/DD/YYYY*

Age: ________ **Sex:** M F **Referring Physician:** ______________________

Primary Care Physician: ______________________

MEDICAL HISTORY: (PAST OR PRESENT)

1. Nose / Sinus Symptoms – When did your symptoms start? (Age or Year) ______________________

Please circle your symptoms:

Runny nose	Sinus headaches	Nasal Itchiness	Bad breath/taste	Itchy ears
Sneezing	Sinus infections	Throat itchiness	Itchy Eyes	Ear aches
Post nasal drainage	Nose Bleeds	Sore throat	Watery Eyes	Ear infections
Nasal congestion	Nasal Polyps	Lack of smell/taste	Snoring	Ear tubes

When do your symptoms appear or worsen?

Sleep Awakening Work Indoors Outdoors Vacation Exercise Emotional upset **Weather changes**

Circle months that your symptoms are worse: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

2. Please circle any of these things that make your condition worse or trigger your symptoms:

Dampness	Heat	Cold air	Air conditioning	Sunlight
Irritant fumes/aerosols/sprays		Smog	Cosmetics/perfumes	Tobacco smoke
Newsprint	House dust	Road dust	Cutting grass	Restaurant Meals
Dogs	Birds/feathers	Cats	Other Animals	Beer/Wine
Newsprint	Menstrual Cycle	Stress	Chocolate	Acid Reflux/Heartburn

Sleep Apnea: Yes or No If yes, do you wear a CPAP? Yes or No What is your CPAP setting? ____________

Have you ever had an Ear Nose & Throat Doctor evaluation? Yes or No When? ______________________

Please list & date any **nasal/sinus** surgeries: ______________________________________

3. Asthma/Chest Symptoms – Do you have a history of Asthma? Yes or No When did they start? ______________

Please circle your symptoms: Cough Shortness of Breath: at rest / with exercise

Wheezing Increased Mucus Chest infections Frequent Pneumonia Frequent Bronchitis

If yes, Have you ever been hospitalized for asthma in the past? Yes or No
Have you ever been in ICU or been Intubated for asthma in the past? Yes or No
Have you ever received oral or intravenous steroids for asthma in the past? Y / N Last time received ________
Have you ever received steroid inhalers? Yes or No
Do you have rescue inhalers like Albuterol/Ventolin/Pro-Air HFA/Proventil? Yes or No

How many times do you need your recuse inhaler? ____per Day ____ per Week ____ per Month _____ per Year

Do you need your rescue inhaler more when you are sick? Yes or No When exercising? Yes or No

Other Chest Illnesses: **COPD** Pneumonia Tuberculosis Cystic Fibrosis Bronchiectasis Interstitial lung Blood clots

PATIENT: ____________________

4. **Skin / General Symptoms – When did your symptoms start? (Age or Year)** ____________________

Eczema Skin rashes Hives Itchiness Psoriasis

Do you have reactions to metals/chemicals/cosmetics/detergents? Please Explain ____________________

____

Do you have skin reactions when you are in the cold or in the heat? Yes or No

Reactions to poison ivy/oak? Yes or No **Reaction to Latex?** Yes or No

Have you had reactions that resulted in: Lip or throat swelling or Anaphylactic reaction (Yes or No)

If yes, please explain: ____________________

5. **Food Reactions? Yes or No When did your symptoms start? (Age or Year)** ____________________

Please list food below:	**Please list reaction below:**

Previous Allergy Testing:

Have you ever been skin tested? Yes or No If yes, when? __________ Results? __________
Have you ever taken Allergy Shots? Yes or No If yes, when? ____________________
Did you have reactions to the Allergy Shots? Yes or No If yes, Mild Moderate Severe
Did you stop taking Allergy Shots? Yes or No If yes, Reason for stopping: ____________________

Have you ever had previous bloodwork for RAST testing to test for specific allergens? Yes or No
What were the results? ____________________

Are you on a BETA BLOCKER OR RECENT/CURRENT STERIODS? Yes or No
Do you carry an Epi- Pen Auto injector or an Auvi-Q Auto Injector? Yes or No

Do you take antihistamines? (Example: Zyrtec, Allegra, Claritin, Xyzal, etc)? If yes, please list ____________________
Do you get drowsy/tired when you take your antihistamine? Yes or No
Do you use nasal sprays? Yes or No Do they work (Good) or (Bad)?

Do you have ALLERGIES OR ADVERSE REACTIONS to medications? Yes, (explain below) or No

Medication	Type of Reaction to Medication

PRESENT MEDICATIONS: (See Attached List)

Name of Drug	Dose (Amount & how many times per day?)		
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	

PATIENT:___________________________

REVIEW OF SYSTEMS: Please circle any that apply.

General: Fever Chills Night sweats Weight gain Weight loss Fatigue Anemia High cholesterol

Endocrine: Diabetes (Type 1) or (Type 2) Low Blood Sugar Thyroid disorders Osteoporosis Pituitary Adrenal

Cardiovascular: **Hypertension** (High Blood Pressure): Y / N Chest Pain Short of Breath Heart Murmurs Arrhythmias Clots

GI/GU: Abdominal pain IBS Nausea Vomiting Acid reflux Heartburn Ulcer Burning on urination Blood in urine / stool

Females: **Are you currently pregnant or plan on becoming pregnant in the immediate future? Yes or No**

If Yes, when are you due? _______________ Males: Prostate problems? Yes No

Musculoskeletal: Muscle problems Joint problems / Arthritis SLE (Lupus) Osteoarthritis Peripheral artery disease Vasculitis

Neurological problems: Sleepiness Weakness Loss of sensation Multiple Sclerosis Autism Tremor Seizures Memory

Psychiatric: Depression Anxiety Phobias Bipolar ADHD Infectious: Viral Bacterial Parasitic Lyme disease Shingles

Please list Health conditions / Chronic Illnesses' / Past major Illnesses that you suffer from:

____

____

____

Operations & Major Hospitalizations (Include Reason/Date):_______________________________

____

____

Are your immunizations up-to-date? Y / N **X-Rays**: Last Chest X-Ray? __________ Last Sinus X-Ray? ___________

FAMILY HISTORY OF ALLERGIES: Yes / No If yes, please circle any who have allergies:

Mother Father Sister Brother Maternal Grandparent Paternal Grandparent Aunt Uncle

Sinus Asthma Eczema Medications Food Hives Insects/Bee Other: ________________________

PATIENT:_______________________________

SOCIAL HISTORY & ENVIRONMENTAL EXPOSURES:

HABITS: Do you smoke? Y / N How many years? ______ If no, have you smoked in the past? Y / N How long? _______

Are you exposed to second-hand smoke? Y / N Does anyone smoke at home? Yes No Outside

Do you drink alcohol? Y / N If yes, how many drinks per week? _____ Do you use drugs? Y / N ___________

WORK: Job Description: ________________________________ How long have you had this job? ___________

Are you exposed to: Chemicals Fumes Dust Animals Latex Other ________________ at work?

IF **STUDENT:** Grade_____ Exposed in school: Air Conditioning Heat Dust Mold Class Pets

HOBBIES: Chemicals Fumes Paint Thinners Gardening Welding **Outdoor activities** **Indoor activities**

HOME: Please circle the correct answers: Location of Dwelling: Rural City Village

Type of Dwelling: House Apartment Mobile/Motor home Age of Dwelling: _______years Years of occupancy________

Heating: Gas/Wood stove/Baseboard/Other _____________ Air Conditioning: Central/Window units/Other Humidifier

Air purifier: HEPA filter/Electronic/Other Flooring: Carpet? Y / N How old? _____ Hardwood Vinyl Tile Area rugs

Dogs: Number____ Indoor/Access to bedroom or bed/Outdoor **Cats:** Number____ Indoor/Access to bedroom or bed/Outdoor

Other pets: ________________ Exposure: House plants Obvious mildew/mold Roaches Mice

Bedroom furnishings: Circle type of pillow: Feather / Cotton / Nylon / Memory foam How old? ____ Months/Years

Circle type of mattress: Regular / Feather top / Pillow top: How old? ____ Months/ Years Box spring? Yes No

Feather / Cotton comforter? Special allergy cover for pillow? Yes No Special allergy cover for mattress? Yes No

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I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures, and patient care which, in the judgment of my provider maybe be considered necessary or advisable while a patient at Allergy Care, PLLC.

_______________________________ ___________

Patient/Parent Signature Date

INITIALS/DATE: Receptionist________________ Nurse____________________ MD____________________

2017