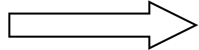
**ALLERGY & ASTHMA CONSULTANTS P.C.**
4104 Old Vestal Rd #108
Vestal, NY 13850
Ph: 607-729-0726
Email: AllergyAsthmaVestal@gmail.com

Mohan Dhillon MD,FAAAI,FRCP (c)
Eleanore Kellicutt, FNP, BC
website: www.broomeallergy.com
Fax: 607-729-1341

____________________________________ has been scheduled for a Consultation / Consultation with Allergy Testing

On__________________________________________ at ______________ am / pm. You can cancel or re-schedule your appointment by calling us at # 607-729-0726. Please leave a message on our answering machine if you call during non-office hours. 24 hour notice required for cancellations.

AS WE ARE AN ALLERGY OFFICE, **DO NOT** WEAR HEAVY PERFUMES OR COLOGNES TO THIS APPOINTMENT. THESE SCENTS CAUSE SEVERE ALLERGIC REACTIONS TO MANY OF OUR PATIENTS AND STAFF. **IF YOU ENTER OUR OFFICE WITH THESE ON, YOU WILL BE RESCHEDULED. You are also required to bring your insurance card(s) and a photo ID of the patient, or if the patient is a minor, the adult who is accompanying them.**

**PAPERWORK:** Your paperwork needs to be sent back to us prior to your appointment. If we do not have it before then, you will be asked to come to the office ½ hour earlier then written above

**ALLERGY TESTING**: Only if you are scheduled for allergy testing, DO NOT TAKE any medication (prescribed or over the counter) containing decongestants or antihistamines, five (5) days prior to your appointment or you cannot be tested. Call us if you have questions about medication. If your allergy symptoms are too severe without taking medication, please continue to take it, but still come for your scheduled appointment.

**HIVES**: If you are experiencing hives please continue to take your medication as you cannot be allergy tested during a breakout. The doctor may schedule testing for a later date or lab work if appropriate. If you are able, please take photographs and bring them to your appointment or email them ahead of time. These will be kept on your electronic medical record for reference.

**MEDICAL INSURANCE: Our office accepts most insurance plans. You are still responsible for office co-pays, which are due the day of your visit. If you are unsure of your insurance benefits, please call the customer service number located on your insurance card to inquire about coverage.**

**CANCELLATIONS AND NO-SHOW POLICY**: If you no-show or cancel your evaluation three (3) times, you will not be scheduled by our office again and your referring doctor will be notified.

**SELF PAY**: Payments are due the day of your visit by cash or credit card only (Visa or Master Card). We do not accept personal checks for a new patient appointment.

Sincerely,

Allergy & Asthma Staff

**Last revised: 2.27.17**

# Allergy & Asthma Consultants PC

4104 Old Vestal Rd 108
Vestal, NY 13850
607-729-0726 / www.broomeallergy.com

Welcome to Allergy & Asthma Consultants. We look forward to providing quality care to you, but before we can proceed, we need you to agree to the following terms: Please understand we expect monthly payments on account balances. This office accepts Visa, Master Card or health spending account credit cards. Checks are accepted with a valid photo ID, but returned checks are subject to additional service fees and could result in not accepting your personal checks after that.

**INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS**: All co-payments are due to Allergy & Asthma Consultants on the day services are rendered. Patient agrees to pay what their insurance states is their responsibility. Office billing statements are mailed out monthly, only after the insurance carrier has processed your claim.

YOU, the patient/and or parents of a minor, are responsible to render payment due for treatment, should there be a remaining balance due to co-pays, co-insurance or high deductibles.

Claim payments denied by the insurance carrier for “non-coverage” or “no insurance referral on file”, become the responsibility of the patient and you agree not to withhold payment from our office in the event of a dispute between you and your medical insurance carrier. Although we make every effort to obtain accurate information from you (or your referring medical office) prior to the appointment, verification of benefits is not a guarantee that the insurance carrier will pay a claim, or pay the amount estimated.

***Patients are responsible for checking their benefits prior to treatment***. The insurance carrier makes final determination, based upon the plan's level of coverage and associated policies, upon receiving the claim. You are also responsible to notify us immediately if your insurance has changed for any reason.

All unpaid accounts are sent to collection if a payment is not made after 90 days and may adversely affect your credit. You agree to pay all fees incurred in the pursuit of delinquent account balances.

In the event that a patient does not have insurance and is paying by cash or credit card, we offer a discount off of our billable amounts.

**I have read the above information and agree to all the terms and conditions contained therein.**

________________________________________DOB: ____________________ ________________________________
(Print Patient Name) Date

__________________________________________________ ______________________________________________
(Print Responsible Persons Name) (Responsible Party Signature)

**<u>**PLEASE NOTE:**</u>** If using a GPS (TomTom, Garman, Phone Data Maps, etc) use the address: "4104 VESTAL RD", (**<u>Old</u> Vestal RD**will not come up in GPS systems.**)

**<u>Rt. 17/ Interstate # 86:</u>** Use exit #70 South (exit just before or after Oakdale Mall depending on your direction) and take the #201 Bridge straight over into Vestal. Stay in the right lane. The first exit on the other side of the river is Old Vestal Rd. Take a right off the exit onto Old Vestal Rd. Vestal Executive Park is the first parking lot on the left before the intersection. After turning into the driveway, turn immediately left again and follow the driveway around the Lourdes Hospice building. This will bring you around to our building on the back left side. (Signs on the Building are: Allergy & Asthma, Dr. Newmark, Manpower, Liberty Mutual)

**<u>From 4 Corners Vestal:</u>** Drive straight on Old Vestal Rd past Walmart/Sams Club, Skate Estate, Staples Plaza until you come to the light at the Buffet Star (corner of Old Vestal Rd and Bunn Hill). Go straight through the light. EBI School is directly on the right. Vestal Executive Park is the first parking lot on the right just past the EBI Building. After turning into the driveway, turn immediately left and follow the driveway around the Lourdes Hospice building. This will bring you around to our building on the back left side. (Signs on the Building are: Allergy & Asthma, Dr. Newmark, Manpower, Liberty Mutual)

**<u>From Binghamton up Vestal Parkway</u>**: Drive up parkway (towards Vestal) and take first right after University Plaza (at the Y) Old Vestal Rd. Continue straight past NYSEG, USH and Texas Roadhouse. Right after your drive underneath the #201 Bridge, we are the first parking lot on the left (Vestal Executive Park). After turning into the driveway, turn immediately left again and follow the driveway around the Lourdes Hospice building. This will bring you around to our building on the back left side. (Signs on the Building are: Allergy & Asthma, Dr. Newmark, Manpower, Beltone)

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Fax: 607-729-1341

(**Please Print Clearly**)

Patient Name :First:_____________________________. Last:_____________________________. Date of Birth: _____/ _____ /______Age: ______

Male ☐ Female ☐ SS#_____________________________________. Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ Sep ☐ Other

Address:_____________________________________ City:______________________________. State:_________. Zip: ______________________

Home Ph#:____________________________________ Cell#____________________________________Work#_______________________________

Employer Name:____________________________________________Address:_________________________________________________________

Emergency Contact:__________________________________________ Ph#__________________________ Relationship:______________________

Is the patient a full time student? ☐ Yes ☐ No School attending:_______________________________________________________________

Referring Doctor:______________________________ Address:_________________________________________ Ph#_________________________

Primary Care Doctor:___________________________ Address:_________________________________________Ph#_________________________

**( Fill In Only If Patient Is A Minor )**

Fathers Name:________________________________________ Address:_________________________________________________________

DOB: ____________________Ph#:________________________________________ Employer:______________________________________

Mothers Name:_______________________________________ Address:_________________________________________________________

DOB: ___________________ Ph#:________________________________________ Employer:______________________________________

**Insurance Information**:

**#1 Insurance**:____________________________________________ ID#________________________________ Group#_____________________

Insured Name:___________________________________________ Date of Birth: ______-______-______ Relationship_____________________

Employer:_______________________________________________ Address:_________________________________________________________

**#2 Insurance**:____________________________________________ ID#_________________________________ Group#____________________

Insured Name:___________________________________________ Date of Birth: ______-______-______ Relationship_____________________

Employer:_______________________________________________ Address:_________________________________________________________

**Authorization for Assignment of Benefits and Information Release**: I, the undersigned, authorize payment of medical benefits to Allergy & Asthma Consultants PC for any services and acknowledge that I am financially responsible for any unpaid balance. I further authorize Allergy & Asthma Consultants to release any medical information necessary to process any claims for insurance benefits covering my medical care.

Signature_______________________________________________________________________ Date:___________________________________

(Or signature of parent / guardian if patient is a minor) Relationship:___________________________________________________________

**If the patient is a minor (under 18 years of age) the patient must be accompanied by a parent or guardian.**

**ALLERGY & ASTHMA CONSULTANTS P.C.**

Patient Name:______________________________________________________________ Date of Birth:_________/_________/_________

Pharmacy Name and Location:__________________________________________________________________________________________

| **Allergies (drugs)** | **Reaction** | **Allergies (environmental)** | **Reaction** |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**What symptoms are you being seen for:** ___________________________________________________________________________________

**Medical History & Conditions:** ___________________________________________________________________________________________

_______________________________________________________________________________________________________________________

_______________________________________________________________________________________________________________________

**Surgical History & Dates**: _______________________________________________________________________________________________

_______________________________________________________________________________________________________________________

_______________________________________________________________________________________________________________________

**Family History (list relationship and their medical condition)** ___________________________________________________________________

_______________________________________________________________________________________________________________________

_______________________________________________________________________________________________________________________

_______________________________________________________________________________________________________________________

**Current Medications: (please bring a list if needed)**

| **Name** | **For what medical condition** | **Dose** | **Times per day** |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# ALLERGY HISTORY QUESTIONNAIRE

Patient Name: ______________________________________________ Today's Date: __________________________

DOB: ______________________ Age: ____________

| | Yes | No | Not Sure |
|---|---|---|---|
| **Trouble with skin?** | | | |
| Eczema | ☐ | ☐ | ☐ |
| Hives | ☐ | ☐ | ☐ |
| **Ears**? | | | |
| Popping | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Hearing loss | ☐ | ☐ | ☐ |
| Fluid in ears | ☐ | ☐ | ☐ |
| Infection/Pain | ☐ | ☐ | ☐ |
| **Throat**? | | | |
| Frequently sore | ☐ | ☐ | ☐ |
| Post nasal drip | ☐ | ☐ | ☐ |
| Itchy throat/mouth | ☐ | ☐ | ☐ |
| **Eyes**? | | | |
| Redness | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Tearing | ☐ | ☐ | ☐ |
| Puffiness | ☐ | ☐ | ☐ |
| **Nose**? | | | |
| Clear discharge | ☐ | ☐ | ☐ |
| Colored discharge | ☐ | ☐ | ☐ |
| Nasal itching | ☐ | ☐ | ☐ |
| Constant stuffy | ☐ | ☐ | ☐ |
| Periodic stuffy | ☐ | ☐ | ☐ |
| Sniffing | ☐ | ☐ | ☐ |
| Sneezing | ☐ | ☐ | ☐ |
| Mouth breathing | ☐ | ☐ | ☐ |
| Snoring | ☐ | ☐ | ☐ |
| **Chest**? | | | |
| Wheezing with colds? | ☐ | ☐ | ☐ |
| Wheezing when Exposed to dust, pollen, pets, etc? | ☐ | ☐ | ☐ |
| Wheeze after exercise? | ☐ | ☐ | ☐ |
| **What kind of cough**? | | | |
| Deep/productive | ☐ | ☐ | ☐ |
| Loose | ☐ | ☐ | ☐ |
| Constant | ☐ | ☐ | ☐ |
| Dry/tight | ☐ | ☐ | ☐ |
| Daytime | ☐ | ☐ | ☐ |
| Nighttime | ☐ | ☐ | ☐ |
| **Are your symptoms** : | | | |
| Mild | ☐ | ☐ | ☐ |
| Moderate | ☐ | ☐ | ☐ |
| Severe | ☐ | ☐ | ☐ |
| Most of the time | ☐ | ☐ | ☐ |
| Part of the time | ☐ | ☐ | ☐ |
| Rarely | ☐ | ☐ | ☐ |
| Interfering with normal activities | ☐ | ☐ | ☐ |
| Preventing normal activities? | ☐ | ☐ | ☐ |

| **Which of the following do you think cause your symptoms or make them worse?** | Yes | No | Not Sure |
|---|---|---|---|
| Indoors | ☐ | ☐ | ☐ |
| Outdoors | ☐ | ☐ | ☐ |
| At home | ☐ | ☐ | ☐ |
| At work | ☐ | ☐ | ☐ |
| Morning | ☐ | ☐ | ☐ |
| Afternoon | ☐ | ☐ | ☐ |
| Nighttime | ☐ | ☐ | ☐ |
| Weather changes | ☐ | ☐ | ☐ |
| Wet weather | ☐ | ☐ | ☐ |
| Dry weather | ☐ | ☐ | ☐ |
| Windy | ☐ | ☐ | ☐ |
| Hot days | ☐ | ☐ | ☐ |
| Cold days | ☐ | ☐ | ☐ |
| Air conditioning | ☐ | ☐ | ☐ |
| In barns | ☐ | ☐ | ☐ |
| Dampness | ☐ | ☐ | ☐ |
| Hay | ☐ | ☐ | ☐ |
| Mowing lawn | ☐ | ☐ | ☐ |
| Dust | ☐ | ☐ | ☐ |
| Animals | ☐ | ☐ | ☐ |
| Cooking odors | ☐ | ☐ | ☐ |
| Smoke | ☐ | ☐ | ☐ |
| Soap | ☐ | ☐ | ☐ |
| Insecticides | ☐ | ☐ | ☐ |
| Paint fumes | ☐ | ☐ | ☐ |
| Perfumes | ☐ | ☐ | ☐ |
| Cosmetics | ☐ | ☐ | ☐ |
| Hair solon products/perm/color/straightener | ☐ | ☐ | ☐ |
| Newspaper | ☐ | ☐ | ☐ |
| Wool | ☐ | ☐ | ☐ |
| Road dust | ☐ | ☐ | ☐ |
| Milk or milk Products | ☐ | ☐ | ☐ |
| Eggs | ☐ | ☐ | ☐ |
| Wheat products | ☐ | ☐ | ☐ |
| Nuts/beans/seeds | ☐ | ☐ | ☐ |
| Chocolate | ☐ | ☐ | ☐ |
| Fish | ☐ | ☐ | ☐ |
| Chicken | ☐ | ☐ | ☐ |
| Red meat | ☐ | ☐ | ☐ |
| Pork | ☐ | ☐ | ☐ |
| Fruit | ☐ | ☐ | ☐ |
| Vegetables | ☐ | ☐ | ☐ |
| Cheese,mushroom | ☐ | ☐ | ☐ |
| Alcoholic drinks | ☐ | ☐ | ☐ |
| Beer | ☐ | ☐ | ☐ |
| Wine | ☐ | ☐ | ☐ |
| Aspirin | ☐ | ☐ | ☐ |

**Other:** ______________________________

______________________________________

______________________________________

**Do certain chemicals make symptoms worse?:** Please list:

______________________________

______________________________

______________________________

**Do certain drugs make symptoms worse?**
Please list:

______________________________

______________________________

______________________________

**During what months do you have symptoms? Check all that apply.**

| | |
|---|---|
| All year round | ☐ |
| January | ☐ |
| February | ☐ |
| March | ☐ |
| April | ☐ |
| May | ☐ |
| June | ☐ |
| July | ☐ |
| August | ☐ |
| September | ☐ |
| October | ☐ |
| November | ☐ |
| December | ☐ |

**What symptoms bother you most**?

______________________________

______________________________

**When or at what age did your symptoms start**?

______________________________

**Do you use medication regularly for allergy symptoms**? Yes ☐ No ☐

If yes, what medication(s):

______________________________

______________________________

______________________________

**Does medication help**?
Yes ☐ No ☐ sometimes ☐

**Do you take any of these medicines daily or frequently?**

| | Daily | Sometimes | No |
|---|---|---|---|
| Aspirin | ☐ | ☐ | ☐ |
| Cortisone | ☐ | ☐ | ☐ |
| Laxatives | ☐ | ☐ | ☐ |
| Sedatives | ☐ | ☐ | ☐ |
| Antihistamines | ☐ | ☐ | ☐ |
| Decongestants | ☐ | ☐ | ☐ |
| Birth control pills | ☐ | ☐ | ☐ |
| Vitamins | ☐ | ☐ | ☐ |
| Ointments | ☐ | ☐ | ☐ |
| Nose drops/sprays | ☐ | ☐ | ☐ |
| Hormones | ☐ | ☐ | ☐ |

**Do any family members have allergies?**
Yes ☐ No ☐ Not sure ☐

**If yes, who**? And do you know what they are allergic to?

___________________________________

___________________________________

___________________________________

___________________________________

**Is there anything about your allergy problems that you think we should know**?

___________________________________

___________________________________

___________________________________

**Are there smokers in the home**?
Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

If yes, Cigarettes #_________ per day

Pipe Yes ☐ No ☐

Cigar Yes ☐ No ☐

Years smoked _____________________

Date stopped smoking_______________

**Do you have hobbies or play sports?: Please list:**

___________________________________

___________________________________

___________________________________

**Have you had pets in the home previously?**
Yes ☐ No ☐

**Are there animals in the home currently**?
Yes ☐ No ☐

If yes to either, what kind and how many:

___________________________________

___________________________________

___________________________________

| Do you live in a: | Yes | No |
|---|---|---|
| House | ☐ | ☐ |
| Apartment | ☐ | ☐ |
| In the city | ☐ | ☐ |
| In the suburbs | ☐ | ☐ |
| Is your house/apt new? | ☐ | ☐ |
| 3-10 years old | ☐ | ☐ |
| 11-25 years old | ☐ | ☐ |
| 26 years or older | ☐ | ☐ |

| Have you had any of the following? | | |
|---|---|---|
| High blood pressure | ☐ | ☐ |
| Migraine headaches | ☐ | ☐ |
| Regular daily headaches | ☐ | ☐ |
| Skin disease | ☐ | ☐ |
| Heart disease | ☐ | ☐ |
| Sinus disease | ☐ | ☐ |
| Stomach disease | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Nasal polyps | ☐ | ☐ |
| Nasal surgery | ☐ | ☐ |
| Broken nose | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| (Over active) thyroid | ☐ | ☐ |
| (Under active) thyroid | ☐ | ☐ |
| Bronchitis | ☐ | ☐ |
| Hay fever | ☐ | ☐ |
| Deviated septum | ☐ | ☐ |
| Hormonal difficulty | ☐ | ☐ |
| Hives | ☐ | ☐ |

**Known food allergies, if yes please list with allergic reaction:**

___________________________________

___________________________________

___________________________________

**Please describe your place of employment and occupation, or where you go to school:**

___________________________________

___________________________________

___________________________________

**Are there any materials used at work or school that you think might be bothering you? If yes please describe:**

___________________________________

___________________________________

___________________________________

**Are your symptoms better at:**
- **Work** ☐
- **Home** ☐
- School ☐
- The same at both ☐
- Not sure ☐

**Do you sleep with a pillow?**
- Is it Dacron ☐
- Foam rubber ☐
- Feather ☐
- Synthetic stuffing ☐
- Other:___________________________
- Not sure ☐

**Is your mattress:**
- Feather ☐
- Foam rubber ☐
- Cotton ☐
- Other_____________________ ☐
- Not sure ☐

| | Yes | No |
|---|---|---|
| Do you use a humidifier | ☐ | ☐ |
| Air conditioner | ☐ | ☐ |
| At work | ☐ | ☐ |
| At home | ☐ | ☐ |
| In bedroom | ☐ | ☐ |
| Central air | ☐ | ☐ |

**Is your heating system**
- Oil ☐
- Gas ☐
- Electric ☐
- Coal ☐
- Wood stove ☐
- Other:___________________________

**Is your heat delivered by:**
- Blower ☐
- Radiators ☐
- Electric panels ☐
- Other: ___________________________

## Health Information Protection Privacy Act (HIPPA)

## Consent for disclosure of protected health information

By signing this form, you give consent for Allergy & Asthma Consultants PC to use and disclose your private and protected health information for the purpose of treatment and/or payment. Our Health Information Privacy information, which is located in our office waiting room, explains in detail how we use your health information. We encourage you to please pick up a copy if you are unfamiliar with this privacy act.

You can revoke any person given consent on this form by contacting our office directly by phone or written request.

Patient Name: ____________________________________________________________ Date of Birth:___________________________

(please print)

I give the following listed individuals permission to speak directly to Allergy & Asthma Consultants about my medical care. I also understand I can revoke this permission at any time.

Name:________________________________________________________ relationship:____________________________________

Name:________________________________________________________ relationship:____________________________________

Name:________________________________________________________ relationship:____________________________________

Patient Signature:_____________________________________________________________ Date:_____________________________

(signature of parent or guardian if patient is a minor)

Relationship to patient (if minor):____________________________________________________

# HealthlinkNY Health Information Exchange

LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: **ALLERGY & ASTHMA CONSULTANTS PC**

I understand that I can choose whether to allow the Provider Organization or Health Plan named above to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I get health care. HealthlinkNY is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPPA and New York State Law. To learn more visit the HealthlinkNY website at www.healthlinkny.com.

**Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or deny consent may not be the basis for denial of health services. The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills.**

**Please carefully read the Consent Form Information Sheet about how your information is used before making your decision.**

**Your Consent Choices:** You can fill out this form now or in the future. You can also change your decision at any time by completing a new form.

**Please choose only one of the following two options:**

☐ **I GIVE CONSENT** for the Provider Organization or Health Plan named above to access ALL of my Electronic health information through HealthlinkNY in connection with providing me health care Services, including emergency care.

☐ **I DENY CONSENT** for the Provider Organization or Health Plan named above to access my electronic Health information through HealthlinkNY for any purpose, ***EVEN IN AN EMERGENCY.***

If you want to deny consent for all Provider Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050.

| _______________________ | _______________________ | _______________________ |
|---|---|---|
| Printed Name of Patient (Last Name) | (First Name) | Patient Date of Birth (MM / DD / YYYY) |

| _______________________ | _______________________ |
|---|---|
| Signature of Patient or Patient's Legal Representative | Relationship of Legal Representative to Patient (If applicable) |

| _______________________ | _______________________ |
|---|---|
| Date of Signature (MM / DD / YYYY) | Print Name or Legal Representative (if applicable) Last Name, First Name |

HealthlinkNY * (844) 840-0050 * www.healthlinkny.com
49 Court Street, Suite 300 * Binghamton, New York 13901
300 Westage Business Center Drive, Suite 150 * Fishkill, NY 12524