Allergy & Asthma Care, Inc.
John Seyerle, MD and Ashish Mathur, MD
Board Certified, Allergy and Immunology
Specializing in Adult and Pediatric Allergies and Asthma

You have an appointment at Allergy & Asthma Care at the following address:

Richmond Office
4718 National Rd. E.
Richmond, IN 47374
765.966.0390
765.966.3343

You can visit our website at www.allergy-asthmacare.com Please call 765.966.0390 with any questions or concerns.

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR VISIT

Name: _____
DOB: _____
Primary Care Doctor: _____
Referred by: _____

Welcome. What brings you to see us today? _____
_____
When did you take your last antihistamine?_____

1. ALLERGY / SINUS - Age first noticed _____

Symptoms - *check all that apply*

	Runny nose		Sinus infections		Ears plugged up		Wheezing
	Congestion		Sneezing		Itchy eyes		Chest tightness
	Itchy nose		Change in taste or smell		Watery eyes		Exercise intolerance
	Post nasal drip		Headaches		Coughing		

List treatments that have helped_____

Treatments that have not helped_____

Triggers - *check all that apply*

	Spring		Cut grass		Exercise		Cleaning agents/bleach
	Summer		Raking leaves		Laughter		Cigarette smoke
	Fall		Other outdoor		Stress		Perfumes and odors
	Winter		Moldy places		Menstruation		Foods
	Year round		Dust		Pregnancy		Medications
	Weather changes		Animals/pets		Alcohol		Colds/viruses

2. ASTHMA - Age at first diagnosis_____

Symptoms - *check all that apply*

	Cough		Shortness of breath		Throat tightness
	Wheeze		Chest tightness		Chest burning
	Mucous		Chest pain		Other

Number of asthma hospital admissions ever: _____ In the last 12 months: _____
Number of asthma ICU admissions ever: _____ In the last 12 months: _____
Number of courses of oral steroids for asthma ever: _____ In the last 12 months: _____

(in the past 4 weeks)
Is your asthma well controlled? Y / N
Have you limited your activity due to your asthma? Y / N
Missed work due to your asthma? Y / N
Woken up at night coughing or shortness of breath? Y / N
Maximum number of albuterol puffs in one day:_____
# of days using any albuterol in last month:_____

List treatments that have helped_____

Treatments that have not helped_____

3. ECZEMA - Age first noticed_____ **Frequency:**_____

Describe the rash: _____

List any triggers:_____

List treatments that have helped:_____

Treatments that have not helped:_____

4. HIVES - Age first noticed_____ **Frequency:**_____

Describe the rash: _____

List any triggers:_____

List treatments that have helped:_____

Treatments that have not helped:_____

5. FOOD ALLERGIES - *describe below*

Food	Age	Describe Reaction and Treatment

What foods are you currently avoiding?_____

6. INSECT STING REACTIONS - *describe below*

Insect	Age	Describe Reaction and Treatment

7. CURRENT MEDICATIONS: *please attach list or list all*

8. MEDICATION AND LATEX ALLERGIES - *please list all previous reactions to medications*

Medication	Age	Describe Reaction

9. OTHER MEDICAL HISTORY - *check all that apply*

	High blood pressure		Diabetes/sugar		Thyroid		Other
	Reflux/heartburn		Kidney problems		Cancer		
	Pneumonia		Heart disease		Hepatitis or HIV		

Please list all Surgeries and other medical problems: _____

_____

Infections - *Number in lifetime, if more than zero, please describe and give dates*

	Pneumonia		Fungal infections		Meningitis
	Sinusitis		Skin infections		Ear infections
	Bronchitis		Sepsis		Other

Immunizations - Up to Date? Y / N (explain)_____

Reactions to immunizations, if any_____

Last Tetanus:_____ Flu:_____ Pneumonia:_____

10. FAMILY HISTORY - *if yes, please state who*

	Asthma		Eczema		Cystic Fibrosis
	Allergies		Hives		Cancer
	Food Allergies		Immune Deficiencies		Other

11. ENVIRONMENTAL HISTORY - *Check all that apply*

	House		Basement		Carpeting		Carpet in Bedroom
	Townhouse		Mold or moisture		Wood Floors		Feather/down bedding
	Apartment		Gas Heat		Cats, #		Feather/down pillows
	Condo		Electric Heat		Dogs, #		Dust mite covers
	Mobile home		Central Air		Birds, #		Tobacco Smoke
	City		Window A/C		Other Animals		Other exposures
	Suburb		Wood stove/fireplace				
	Rural		Propane heat				

What is your occupation?_____

Who else lives in your home?_____

Are there any other exposures that you are concerned about?_____

_____

Smoking?

	Current	Age first started -	Below list any household members that smoke
	Quit	Ages last quit -	
	Never	Average packs per day -	

12. OTHER SYMPTOMS - *check all symptoms that you have currently*

	Fever		Chest pain		Abdominal pain		Headaches
	Weight Loss		Palpitations		Heartburn		Dizziness
	Weight gain		Rashes		Nausea		Vision changes
	Fatigue		Dry skin		Vomiting		Numbness
	Muscle aches		Blood in urine		Diarrhea		Depression
	Joint pain		Burning		Constipation		Anxiety

ALLERGY & ASTHMA CARE, INC.

John Seyerle, M.D. Ashish Mathur, M.D.

Please Print

Patients Name_____ D.O.B._____

E-mail Address_____

Because we value your right to privacy, we would like to determine how to best handle our telephone communications with you. We routinely call our patients for the following reasons:

1. To Confirm Appointments
2. With Test Results
3. To Respond To Your Questions or Concerns

In the event we attempt to contact you and you are not available, what would you like us to do?
Leave a message on your answering machine/voice mail

Home Phone Number_____ Cell Phone Number_____

_____Leave the information with:

Last Name:_____ First Name: _____

Relationship:_____ Telephone #:_____

Last Name:_____ First Name:_____

Relationship:_____ Telephone#:_____

_____Do Not leave information about me on an answering machine/voice mail or with another person. Leave a name and telephone number and I will return your call.

By signing this form you are letting us know the best way to provide you with your personal health information by phone. If any of this information changes, you are responsible for notifying us, preferably in writing.

Signature:_____ Date:_____

ALLERGY & ASTHMA CARE, INC.

Account #_____
_____Insurance Change
_____Name/Add. Change

PATIENT INFORMATION

(Please Print)

PATIENT NAME (Last) _____(First) _____(M.I.) _____

STREET ADDRESS_____
CITY _____STATE_____ZIP_____

Birth Date _____Age_____ Sex ____ Home Ph. ( )_____ Cell Ph. ( )_____

Work Ph. ( )_____ Social Security #_____Marital Status__ E-Mail_____

Name/address of Referring M.D._____
Patient's Employer:_____

Name/Address of Pharmacy _____

INSURANCE INFORMATION (All patient MUST provide <u>policy holder</u> information in this section)

PRIMARY INSURANCE: _____ Effective Date: _____
Address: _____
I.D.# _____ Group # _____
Policy Holder Date of Birth: _____ Sex _____
Patient Relation to Policy Holder: _____
Policy Holder's Name: _____ Policy Holder's Employer _____

SECONDARY INSURANCE: _____ Effective Date: _____
Address: _____
I.D. # _____ Group #_____
Policy Holder Date of Birth: _____ Sex _____
Patient Relation to Policy Holder: _____
Policy Holder's Name: _____ Policy Holder's Employer _____

ANY ADDITIONAL COVERAGE? ( ) YES ( ) NO

PATIENT INFORMATION *(continued)*

FINANCIAL RESPONSIBILITY (Person responsible if other than patient)
Must be filled out for ALL patients including minors

NAME (last) _____ (First) _____ (M.I.) _____

STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____

Birth Date _____ Age ____ Sex ___ Home PH ( )_____ Cell PH ( )_____
Work Ph ( )_____ Social Security #_____ Marital Status ___

Name/Address of Primary Care and/or Referring Physician _____
_____
EMPLOYER _____

IS THERE A THIRD PARTY INVOLVED? (i.e. Work Related, Auto Accident)? ( )Yes ( )NO
IF YES, Date of Accident_____ Employer at Time of Accident _____

Please present your insurance card(s) to the receptionist when you have completed this form and sign below.

I hereby authorize treatment. I authorize release of any medical information necessary to process this claim. I understand that my medical insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor, and that I am ultimately responsible for medical fees incurred during my care of care of my dependents.
I hereby authorize Allergy & Asthma Care, Inc. to apply for benefits on my behalf for covered services rendered by them. I also assign all insurance benefits directly to the doctor. I certify that the information I have reported above is correct and true. I permit a copy of this authorization to be used in place of the original.

DATE: _____ X _____
Signature (if minor, please have responsible party sign)

APPOINTMENT REMINDERS

- ***Day of your Appointment:***
  Set aside approximately **3 hours** for your appointment
  Eat prior to your appointment
  Arrive 15 minutes prior to your scheduled appointment time
  Bring completed Patient Information Form and Patient History Questionnaire

- ***Prior to your Appointment:***
  DO NOT STOP taking your **ASTHMA MEDICATIONS**
  Seven days prior to your appointment, **discontinue** taking any medications containing **antihistamines**
  Examples of antihistamines:
  Cold & Sinus Medicines
  Benadryl
  Claritin
  Zyrtec
  Allegra

- ***Helpful information to bring to your appointment:***
  List of Medications you are taking
  Records pertaining to your visit concerning allergies or asthma
  List of questions you have for the doctor
  Name/Address of physicians you see
  Insurance Card(s)

- ***Clothing:***
  Skin testing could be applied to your lower arms and it would be helpful if you could wear short sleeves.

- **Billing:**
  Co-pay/co-insurance will be **collected at time of service**
  Deductable: if deductable has **not been met**, be prepared to **pay a percentage**
  Payment: we accept **Cash, Check, MasterCard, Visa** and **Discover**
  Questions: Any questions or concerns you may have about your insurance, please call our **Insurance Department (1.513.671.0799**) during regular business hours.

We look forward to providing you with quality healthcare.

John Seyerle, M.D. **Ashish Mathur, M.D.** **Allergy & Asthma Care, Inc. Staff**