Allergy & Asthma Care

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:

Clifton Office
2055 Reading Rd. #150
Cincinnati, Ohio 45202
513.861.2323
513.861.0311

You can visit our website at www.allergy-asthmacare.com. Please call 513.861.2323 with any questions or concerns.

ALLERGY & ASTHMA CARE, INC.

PATIENT INFORMATION

PATIENT NAME (First) ____________________ (MI) _____ (Last) ____________________________
Social Security # _ _ _ - _ _ - _ _ _ _ DOB _ _/_ _/_ _ _ _ Sex: __ M __ F
Street Address ____
City ______________________________________ State ___________ Zip __________________
Home Phone # (_ _ _) _ _ _ - _ _ _ _ Cell Phone # (_ _ _) _ _ _ - _ _ _ _
Email ____ Marital Status _______________
Referring Doctor ____

INSURANCE INFORMATION (Policy Holder information is <u>required</u> in order to file your claims.)

PRIMARY ____ Eff Date _ _/_ _/_ _ _ _
Claims Address ____
ID# ______________________________________ Group# ______________________________
Patient Relationship to Policy Holder: __ Self __ Spouse __ Child __ Other (specify) ___________
Policy Holder Name (First) _________________ (MI) ____ (Last) ___________________________
Policy Holder DOB _ _/_ _/_ _ _ _ Policy Holder Sex: __ M __ F

SECONDARY ____ Eff Date _ _/_ _/_ _ _ _
Claims Address ____
ID# ______________________________________ Group# ______________________________
Patient Relationship to Policy Holder: __ Self __ Spouse __ Child __ Other (specify) ___________
Policy Holder Name (First) _________________ (MI) ____ (Last) ___________________________
Policy Holder DOB _ _/_ _/_ _ _ _ Policy Holder Sex: __ M __ F

ADDITIONAL COVERAGE? __ No __ Yes (If "yes," please request additional form and provide details.)

FINANCIAL RESPONSIBILITY

Contact information for a financially responsible adult is <u>required</u> for all patients 17 years of age and younger.

NAME (First) ______________________ (MI) _____ (Last) _____________________________
DOB _ _/_ _/_ _ _ _ Social Security # _ _ _ - _ _ - _ _ _ _ Sex: __ M __ F
Street Address ____
City ______________________________________ State ___________ Zip __________________
Home Phone # (_ _ _) _ _ _ - _ _ _ _ Cell Phone # (_ _ _) _ _ _ - _ _ _ _
Email ____________________________________ Relationship to Patient __________________

Please date and sign below and present this completed form to the receptionist with your insurance card(s).

I hereby authorize treatment. I authorize release of any and all medical information necessary to process my medical claims. I understand that my medical insurance is a contract between myself and my insurance carrier, and not between the insurance carrier and the doctor, and that I am ultimately responsible for all fees incurred during my care and the care of my dependents.

I hereby authorize Allergy & Asthma Care, Inc. to apply for benefits to be paid on my behalf for covered services rendered by their doctors and staff. I also assign all insurance benefits directly to Allergy & Asthma Care, Inc. 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 patient is minor child, parent/guardian must sign)

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 &
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Care

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Please Print

Patient's Name_________________________________ D.O.B.______________
E-Mail Address_________________________________
Cell Phone Number to Receive Texts from Allergy & Asthma Care_______________

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 patient 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________________________

Springdale
422 Ray Norrish Dr. #2
Cincinnati, OH 45246
513.671.6707

Clifton
2055 Reading Rd. #150
Cincinnati, OH 45202
513.861.2323

Anderson
8000 Five Mile Rd. #315
Cincinnati, OH 45230
513.624.6600

Kenwood
4760 E. Galbraith #107
Cincinnati, OH 45236
513.791.1143

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

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**