



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:

TriCounty Office
422 Ray Norrish Dr.
Cincinnati, Ohio 45246
513.671.6707
513.671.6710 (fax)

You can visit our website at www.allergy-asthmacare.com. Please call 513.671.6707 with any questions or concerns.

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

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 required 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 required 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)

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



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 _____

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 deductible 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