THE CENTER FOR ALLERGY ASTHMA & IMMUNE DISORDERS
360 Essex Street, Suite 302 · Hackensack, NJ 07601
Office 551-996-2065 · Fax 551-996-2169

Mary Ann Michelis, MD

Diplomate of the American Board of Allergy & Immunology

WELCOME TO OUR CENTER

Thank you for calling and scheduling your appointment on _____ at _____ am/pm. Please complete the enclosed **Patient Information and Record of Patient's Medical History / Questionnaire,** and fax them to 551-996-2169 or email them to ariciatorres@hackensackumc.org or michelleboguckI@hackensackumc.org. The Questionnaire gives us a sense of your overall health and any conditions that may impact on your allergic and immunologic evaluation. If possible, kindly bring the following items with you or send them to our Center prior to your scheduled visit:

1. Physician's medical records relevant to your chief concern
2. Previous chest x-rays, sinus x-rays, and / or CT scans
3. Results of previous allergy skin testing
4. Your peak flow meter if you have one, and / or results of recent Pulmonary Function Test
5. Bring all your medications, or a list of your medications with doses, including nasal sprays, topical creams, vitamins, herbals and previously used allergy and asthma medications or inhalers if applicable
6. If your visit is for evaluation of recurrent infections, a list of treatments and antibiotics used in the past 12 months would be helpful

ATTENTION ALLERGY PATIENTS:

If you are currently taking **OVER-THE-COUNTER antihistamines**, which include: **Benadryl, Claritin, Alavert, Chlortrimeton, Dimetapp, Dramamine, Tylenol PM, Tylenol Allergy, Rynatuss, Triaminic Rx, and Tavist**, you must discontinue their use **FOUR DAYS** prior to your appointment. If you are taking **PRESCRIPTION antihistamines**, which include: **Antivert, Clarinex, Hismanal, Zyrtec, Allegra, Atarax, SemprexD, Vistaril, and Periactin you may discontinue their use for SEVEN DAYS.** If you are currently taking **Astelin Nasal Spray**, please discontinue for **48 HOURS** prior to your appointment. You may discontinue H2 blockers like Zantac (Ranitidine), Pepcid (Famotidine), and Tagamet (Cimetidine) 24 hours prior to your visit. If you have any questions about any antihistamine medication, please do not hesitate to contact our office and ask to speak with a nurse.

If you are taking Tricyclic or Tricyclic compounds, which include Amitriptyline (Elavil), Nortriptyline (Pamelor), Imipramine (Tofranil), Doxepin (Sinequan), Clomipramine (Anafranil), Trimipramine (Surmontil), or Desipramine), you may not be able to be skin tested.

ATTENTION PATIENTS WITH ASTHMA:

If you are coming to the Center for evaluation of cough, asthma or reactive airway disease, please do not take your bronchodilators on the day of your visit. These include Advair, Proventil, Albuterol, and Xopenex.

ATTENTION MANAGED CARE AND HMO PATIENTS:

While we are pleased to be able to provide service to you, it is very difficult for us to keep up to date with all the specifics and various requirements of each and every plan. Please understand that each plan has different stipulations such as referrals, authorizations, lab work, diagnostic skin tests or challenges, etc. It is very important that you, the patient, come into our office with your **INSURANCE CARD**, a form of identification, and be fully aware of what your insurance plan covers prior to the time of your scheduled appointment. Unfortunately, **we will be unable to see you without the proper documented referral**, if you are insured by an HMO insurance company. As the policy holder, it is your responsibility to know your insurance plan's benefits and limitations. With your cooperation, we, the health care provider, can provide you with all the medical benefits to which you are entitled.

Patient's Name: _____ **Guarantor's Name:** _____

The financial policy of the Center for Allergy, Asthma & Immune Disorders is as follows:

We participate with the following insurance companies:

Advantage Health Plan (IDA)	Medicare
Aetna (**PPO only**)	Medichoice
Beech Street	Oxford Health Plans
Blue Cross / Blue Shield (**PPO only**)	PHCS (Private Health Care Systems)
Cigna (**PPO only**)	Qualcare
Mastercare	United Health Care (**except HMO**)

Medicare patients are required to pay the 20% fee at the time of the service if there is not a secondary insurance. Services that are not routinely covered by Medicare will require a signed ABN (Advance Beneficiary Notices) form.

If your insurance plan requires a co-payment and/or you have not met your deductible, your co-payment and/or deductible must be paid the day of your visit.

TO ALL OTHER PATIENTS –
Payment is to be made at the time services are rendered. As a courtesy, the Center will submit your claim on your behalf and any reimbursement will be made directly to you. The fee for an initial consultation / evaluation could range from $250.00 to $350.00. The fee for an office follow up could range from $90.00 to $170.00.

If diagnostic services are rendered on the day of your visit, such as allergy skin testing, pulmonary function testing, and/or blood work, these fees will be charged and billed by Hackensack University Medical Center. These are separate charges that are not included in the doctor's fee.

Your care may also benefit from an evaluation by our registered dietician. Service is available at the Center, however, reimbursement is not guaranteed.

For your convenience, we accept CASH, CHECKS, and ALL MAJOR CREDIT CARDS.

I understand the financial policy of the Center for Allergy, Asthma & Immune Disorders.

Guarantor: _____
Please sign your name

If you request that we submit your claims to your insurance company on your behalf, and/or for all other participating patients, this notice will also serve as your authorization to release your medical information to your insurance company.

Patient/Guarantor Signature: _____Date _____

NOTE: We are prevented by federal regulations from offering "Professional Courtesy" fees or courtesy "write-offs" of balances. We maintain compliance with this regulation, which ensures equitable treatment for all our patients.

Please be advised that there is a $50 cancellation fee if you do not cancel your appointment at least 24 hours in advance.

Patient's Medicare Authorization

Patient's Name: _____

Patient's Medicare # _____

I request that payment of authorized Medicare benefits be made either to me or my behalf to:

_____, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefit or the benefits payable to related services. I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim. If "other health Insurance" is indicated in Item 9 of the HCFA-1500 forms, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the physician or supplies agrees to accept the charge determine of the Medicare carriers as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination for the Medicare carriers.

Patient's Signature _____ Date _____

Directions to Hackensack University Medical Center
The Center for Allergy, Asthma & Immune Disorders

From George Washington Bridge and East
Follow Route 80 West, staying in local lanes, to Exit 64B. Turn right at light onto Polifly Road. Travel north on Polifly Road. At second light, turn left onto Essex Street. At first light, turn right onto Prospect Avenue. Hackensack University Medical Center is on the right.

From Paterson Area and West
Follow Route 80 East, staying in local lanes to Exit 63B for Rochelle Park and Paramus. (Exit ramp sign says Exit 63) Turn left off exit ramp and turn right at light onto Essex Street. Follow Hospital signs. At sixth light, turn left onto Prospect Avenue. Hackensack University Medical Center is on the right.

From The Garden State Parkway
From the Garden State Parkway, either north or south, take Route 80 East. Follow directions above for Paterson and West

From Southern New Jersey on The N.J. Turnpike
Follow Route 95-N.J. Turnpike North to the junction of Route 80. Take 80 West and stay in lanes for "Local Exits" to exit 64B for Hasbrouck Heights and Newark. Turn right at light onto Polifly Road. Travel north on Polifly Road. At second light, turn left onto Essex Street. At first light, turn right onto Prospect Avenue. Hackensack University Medical Center is on the right

From Northern New Jersey on Route 17
Follow Route 17 South to Essex Street exit. Turn left onto Essex Street. At fifth light, turn left onto Prospect Avenue. Hackensack University Medical Center is on the right.

From Southern New Jersey on Route 17
Follow Route 17 North to Polifly Road turnoff. Go under the Route 80 overpass and turn left at the second light onto Essex Street. Turn right at the first light onto Prospect Avenue. Hackensack University Medical Center is on the right.

Follow signs to ATTACHED MAP of new location 360 Essex Street, suite 302, Hackensack, NJ
Access to the Center for Allergy, Asthma & Immune disorders, Alfred N. Sanzari Building, Suite 302, third floor, 360 Essex Street. Parking for patients is located within the Sanzari Building. The parking entrance is located at the rear of the Sanzari Building on Thompson Street, which can be accessed from both Summit Ave and Prospect Ave. Elevator service is available on each parking level take the elevator to the third floor. The Center's entrance is located left of the elevator in Suite 302.

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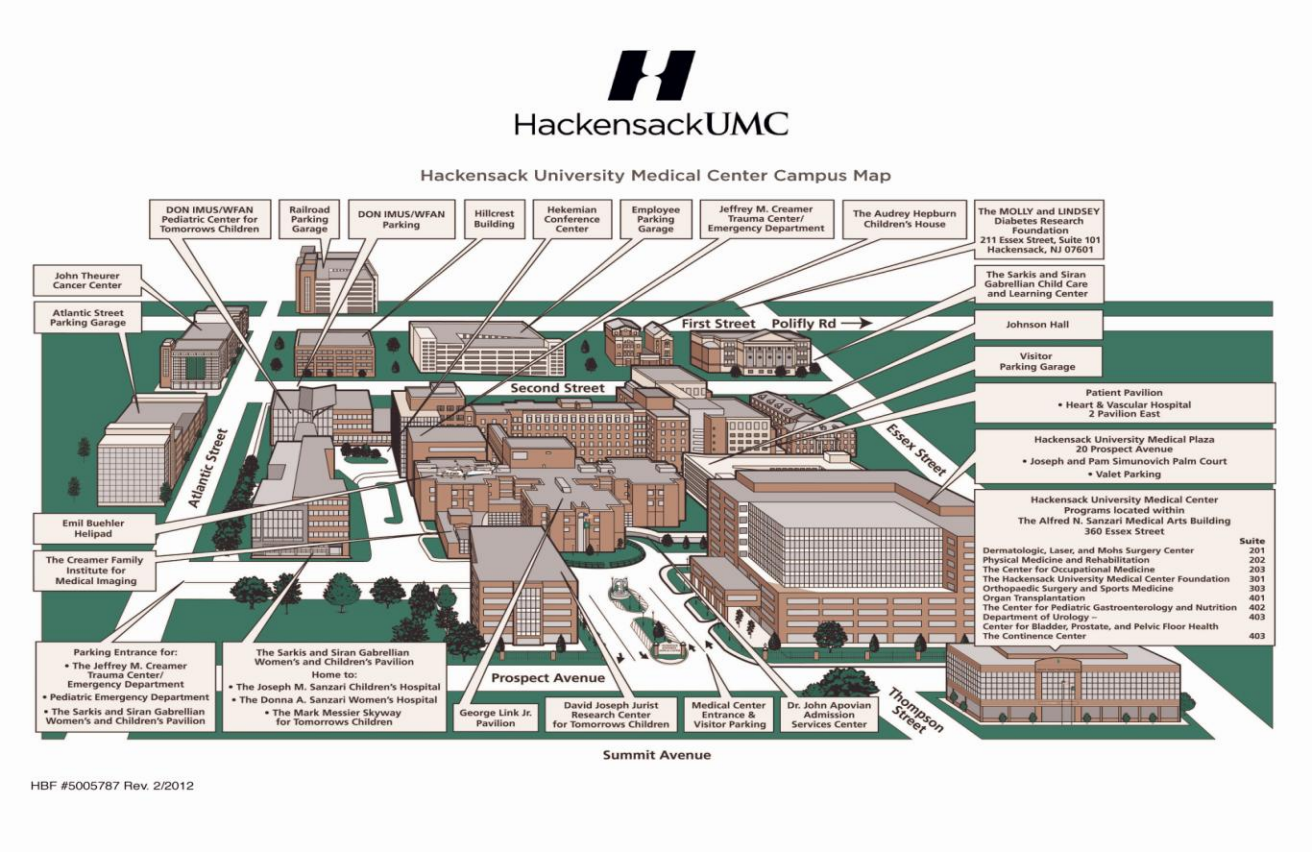

Date _____

PATIENT INFORMATION

Name _____ SS#_____ DOB _____
Marital Status S___M___W___D___ Spouse's Name _____Full Time Student Yes____No____
Address_____City _____State_____Zip_____
Home Phone_____Emergency/Cell Phone_____ E-mail address_____
Patient's Employer_____Employer's Phone_____
Employer's Address_____City_____State_____Zip_____
Referring Physician/Individual_____Phone_____
Address_____City_____State_____Zip_____
Primary Care Physician _____Phone_____
Address_____City_____State_____Zip_____

GUARANTOR INFORMATION

Guarantor's Name_____SS#__ _____DOB_____
Address_____City_____State_____Zip_____
Home Phone_____Relationship to Patient_____Occupation_____
Employer_____ _____Employer's Phone_____Ext._____
Employer's Address_____City_____State_____Zip_____

INSURANCE PLAN INFORMATION

Primary Insurance Plan Name_____Phone_____
Policy ID#_____Group#/Name_____
Address_____City_____State_____Zip_____
Subscriber's Name_____ _____SS#_____DOB_____
Subscriber's Address_____City_____State_____Zip_____
Subscriber's Relationship to Patient_____

Secondary Insurance Plan Name_____Phone_____
Policy ID#_____Group#/Name_____
Address_____City_____State_____Zip_____
Subscriber's Name_____SS#_____DOB_____
Subscriber's Address_____City_____State_____Zip_____
Subscriber's Relationship to Patient_____

I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any claims.
Patient or Guarantor Signature_____Date_____

I request payment of this claim and, if the payer accepts assignment, I authorize payment directly to the physician or supplier of services described.
Patient or Guarantor Signature_____Date_____

IT IS THE RESPONSIBILITY OF THE PATIENT TO CONTACT THE PHYSICIAN IF THERE IS A CHANGE IN ADDRESS, PHONE NUMBER OR INSURANCE.

The Center for Allergy, Asthma & Immune Disorders
Hackensack University Medical Center

Please Print

Name_____ Date_____

RECORD OF PATIENT'S MEDICAL HISTORY

I. List your most important symptoms or reasons for seeking medical attention.

1. _____

2. _____

3. _____

II. Were you referred to us by another physician? □ No □ If yes, name of physician _____

III. Has your general health in the past been good? □ Yes □ If no, please explain: _____

IV. Review of Systems: Please put a √ mark in the following □ if you are experiencing any of these symptoms.
Please put a √ □ no symptoms noted if you are **not** having any of these symptoms.

A. CONSTITUTIONAL □ no symptoms noted
□ fever □ weakness □ fatigue □ unexplained weight loss □ sweats

B. EYES □ no symptoms noted
□ problems with current vision □ changes in vision □ double vision □ pain □ injuries
□ excessive tearing □ discharge □ redness □ infections
□ pain when looking at light □ cataracts □ glaucoma □ macular degeneration
Last eye exam _____

C. EARS □ no symptoms noted
□ hearing loss □ use of hearing aid □ discharge □ dizziness □ pain
□ ringing in the ears □ frequent infections □ 8 or more new ear infections within 1 year

D. NOSE □ no symptoms noted
□ nosebleeds □ infections □ discharge □ nasal obstruction
□ frequent colds □ post-nasal drip □ sinus infections □ itchy nose
□ history of injury to nose □ loss of smell □ 2 or more serious sinus infections within 1 year

E. MOUTH & THROAT □ no symptoms noted
□ hoarseness □ voice changes □ frequent sore throats □ burning of tongue
□ bleeding gums □ mouth ulcers □ loss of taste
□ persistent thrush in the mouth or elsewhere on skin, after age 1
Last dental appointment _____

F. NECK □ no symptoms noted
□ lumps □ goiter □ pain on movement □ tenderness on movement
□ history of swollen glands □ enlarged thyroid

G. CHEST □ no symptoms noted
□ non-productive cough □ productive cough □ shortness of breath □ tuberculosis □ asthma
□ bronchitis □ pleurisy □ coughing up blood □ wheezing
□ 2 or more pneumonias with 1 year
Last chest X-ray _____ Last skin test for TB _____ Last BCG vaccine _____
Mammogram date / findings _____

H. HEAD ☐ no symptoms noted
☐ headaches ☐ migraines ☐ pain ☐ history of head injury ☐ stroke

I. CARDIAC ☐ no symptoms noted
☐ chest pain ☐ high blood pressure ☐ palpitations
☐ heart murmur ☐ enlarged heart ☐ shortness of breath with exertion
☐ shortness of breath when lying flat ☐ sudden shortness of breath while sleeping
☐ history of heart attack ☐ history of rheumatic fever
Last EKG: _____ Any other heart function tests? ☐ Echo date /findings _____
☐ Stress Test date / findings _____ ☐ Thallium Stress Test date / findings _____
☐ Angiogram Test date / findings _____ ☐ Angioplasty date / findings _____

J. GASTROINTESTINAL ☐ no symptoms noted
☐ appetite changes ☐ nausea ☐ swallowing difficulty ☐ change in abdominal size
☐ abdominal pain ☐ constipation ☐ diarrhea ☐ heartburn
☐ vomiting ☐ vomiting up blood ☐ rectal bleeding / pain ☐ black, tarry stools
☐ excessive belching ☐ food intolerance ☐ hemorrhoids ☐ infections
☐ hepatitis / or jaundice ☐ liver disease ☐ gallbladder disease
Abdominal x-rays date / findings _____
Colonoscopy date / findings _____

K. GENITOURINARY ☐ no symptoms noted
☐ frequency ☐ flank pain ☐ difficulty in starting the stream ☐ bedwetting
☐ burning ☐ blood in the urine ☐ infections ☐ incontinence
☐ stones ☐ history of retention ☐ nocturia (gets up at night to go to bathroom)
☐ prostate problems ☐ history of venereal disease or sexually transmitted diseases
☐ pregnant ☐ abnormal menstrual bleeding

L. MUSCULOSKELETAL ☐ no symptoms noted
☐ weakness ☐ paralysis ☐ muscle stiffness ☐ limitation of movement
☐ joint pain ☐ joint stiffness ☐ gout ☐ back problems
☐ muscle cramps ☐ joint deformities

M. NEUROLOGICAL ☐ no symptoms noted
☐ fainting ☐ dizziness ☐ loss of consciousness ☐ paralysis ☐ strokes
☐ numbness ☐ tingling ☐ burning ☐ tremors ☐ loss of memory
☐ speech disorders ☐ unsteadiness of gait

N. PSYCHIATRIC ☐ no symptoms noted
☐ psychiatric disorders ☐ mood changes ☐ general behavioral changes ☐ nervousness

Have you ever been depressed? ☐ No ☐ Yes, and received **no** treatment ☐ Yes, I am on medication.
Have you ever felt like hurting yourself or taking your life in the past? ☐Yes ☐No
Have you ever been hurt by a family member or significant other? ☐Yes ☐No
Do you feel unsafe in your current relationship? ☐Yes ☐No
Have you been left alone too long so that your basic needs are not being met? ☐Yes ☐No
Has anyone taken anything that belongs to you without your ok? ☐Yes ☐No

O. SKIN ☐ no symptoms noted
☐ abnormal pigmentation ☐ rashes ☐ blisters
☐ changes in nail appearance ☐ dryness ☐ hives
☐ change in skin color ☐ changes in hair texture ☐ itching
☐ recurrent, deep skin or organ abscesses

P. ENDOCRINE □ no symptoms noted

□ polydipsia (extreme thirst) □ change in hat or glove size □ abnormal weight gain □ abnormal weight loss

□ extreme appetite □ thyroid problems □ taking replacement hormones medications

Q. HEMATOLOGICAL □ no symptoms noted

□ anemia □ easy bruising □ prolonged bleeding □ abnormal blood counts

□ problem with clotting □ bone marrow cancer □ history of blood transfusions

V. **IMMUNOLOGY / ALLERGY**

□ Immune Problems _____

□ Two or more deep seated infections □ Two or more months on antibiotics with little effect

□ Need for IV antibiotics to clear infections □ Family history of immunodeficiency

□ Not on immunotherapy □ Received immunotherapy or allergy shots in past / dates _____

Have you been previously skin tested for respiratory inhalants, food or drug allergens in the past? □ No □ Yes

DRUG ALLERGIES / REACTIONS**:** □ No □ Yes _____

FOOD ALLERGIES / REACTIONS: □ No □ Yes _____

REACTIONS TO LATEX: □ No □ Yes _____

REACTIONS TO CONTRAST DYES: □ No □ Yes _____

REACTIONS TO VENOM/INSECT BITES □ No □ Yes_____

DID YOU EVER HAVE HIVES IN THE PAST? □ No □ Yes / Date _____

□ General □ Seasonal □ Physical □ Contact □ Hormonal □ Occupational / Recreational

Frequency of Attacks _____ Duration of Attacks _____ Time of Day hives are severe _____

Parts of Body Affected _____

VI. **CURRENT MEDICATIONS:** List **all** the medications you are taking including nasal sprays, inhalers, tablets, creams / ointments, vitamins, minerals and herbal supplements with dosages and frequency. Please include medications you take daily and as needed.

_____ _____ _____

_____ _____ _____

_____ _____ _____

VII**.** **PAST MEDICAL HISTORY:** Please put a √ mark in the following if you have the condition in the past:

□ Diabetes □ Hypertension / high blood pressure □ Thyroid Disease □ GERD / Reflux

□ Heart Disease □ Pneumonia □ Other: _____

Past hospitalizations & emergency room visits**:** _____

VIII. **PAST SURGICAL HISTORY:** _____

VIII. **PERSONAL PREVENTIVE HISTORY:**

What do you do to preserve your eyesight? _____

What do you do to prevent hearing loss? _____

Do you have an Advance Directive? □ No □ Info refused □ Yes / Name of health care proxy _____

Are you able to do daily activities without physical limitations? □ Yes □ No

How much alcohol do you consume in a week? _____

Do you use any illicit drugs? □ Yes □ No

Do you participate in high risk sexual activities increasing your exposures to AIDS/STD? □ Yes □ No

How do you prevent contact with the AIDS virus and other sexually transmitted diseases?

□ Abstains □ Monogamous relationship □ Uses barriers / condoms

Any midlife issues? _____

Daily diet includes □fruits □ vegetables □ dairy products □ grains □ meat / proteins

Do you have any dietary restrictions? □ No □ Yes, _____

How often do you exercise? _____ Type of exercise _____
Do you wear seatbelts in the car? □ Yes, always □ No
What do you do to avoid skin cancer? _____
When did you start smoking? _____ When did you quit? _____ □ Never smoked
How much did you smoke per day? _____ Do you have exposures to second hand smoke? □ Yes □ No

IX **FAMILY HISTORY:**

□ Father Age __ □ In good health □ Health problems _____ □ Deceased /cause of death _____
□ Mother Age __ □ In good health □ Health problems _____ □ Deceased /cause of death _____
How many brothers ___ Ages _____ □ In good health □ Health problems _____
How many sisters ___ Ages _____ □ In good health □ Health problems _____
How many sons _____ Ages _____ □ In good health □ Health problems _____
How many daughters ___Ages _____ □ In good health □ Health problems _____

X. **ENVIRONMENTAL SURVEY**

Do you live in the □city, □ rural or □ suburbs? Do you live in an □ apartment, □ single family home, or □ multiple family home? Approximately how old is the building? _____
The outside construction of the home is mainly □ brick □ wood □ vinyl siding □ stucco.
The rooms inside are □ damp □ not damp □ musty or □ not musty.
Do you use an □ air cleaner □ air dehumidifier ?
Do you have □ indoor plants □ no indoor plants?
I heat the house with □ forced air □ steam □ space heater □ baseboard
□ electric □ wood stove □ fireplace

Type of air conditioning: □ central □ window units □ attic fan

My bedroom floor is □ wood □ vinyl □ tile □ wool carpet □ synthetic carpet □ area rug
My living room floor is □ wood □ vinyl □ tile □ wool carpet □ synthetic carpet □ area rug

My bed is made of: □ foam rubber mattress □ innerspring cotton □ waterbed □ enclosed in plastic which is _____ years / months old.

My pillows are made of: □ feather □ synthetic □ foam rubber □ enclosed in plastic, which is _____ years / months old.

I have □ stuffed animals □ feather comforters.

I have pets at home: □ none □ dogs □ cats □ birds □ other _____,
who are allowed □ outside □ inside and □ in the bedroom.
I have had them for _____years / months.

I work as an □ office professional □ medical professional □ homemaker
□ a production worker □ retired □ student □ other

I am medically disabled since _____ from _____.

I spend most of my time □ indoors □ outdoors

When I am at work, I have exposures to □ cigarette smoke □ dust
□ chemicals □ moldy or mildewed areas □ fumes
Other exposures from recreational activities include □ none
□ outdoor sports □ indoor sports □ others

WE THANK YOU FOR COMPLETING THE ABOVE QUESTIONNAIRE.
WE ARE LOOKING FORWARD TO WORKING WITH YOU AT THE ALLERGY CENTER.