

## **Pediatric and Adult Asthma, Allergy & Immunology**

### **New Patient Forms**

#### **PLEASE READ**

Completing these forms in advance of your visit can save you significant time in the waiting room and during your visit.

It is important that you use **BLACK INK**.

If your insurance requires that you obtain a referral from your primary physician prior to seeing a specialist, it is mandatory that we have the referral at the time of your visit. Otherwise, your visit will need to be rescheduled.

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## NEW PATIENT QUESTIONNAIRE

Please answer all the questions that apply to you or your child (hereafter referred to as "you") and bring this form with you on the day of your visit.

<b>PATIENT'S NAME:</b>	<b>DATE OF BIRTH:</b>
<b>REFERRED TO THIS OFFICE BY:</b>	<b>PRIMARY CARE PHYSICIAN:</b>
	<b>ADDRESS:</b>
	<b>PHONE:</b>

1. **CHIEF COMPLAINT (Reason for Visit):** \_\_\_\_\_

\_\_\_\_\_

2. **HISTORY OF PRESENT ILLNESS (PHYSICIAN TO COMPLETE):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. **REVIEW OF SYSTEMS (PROBLEMS):** Have you had any of the following symptoms or conditions?  
Check all that apply.

System	No	Yes	Check all that apply	Age of onset	All-year or seasonal?	Indoor or outdoor?	Comments
Eyes			<input type="checkbox"/> red, <input type="checkbox"/> watery, <input type="checkbox"/> itchy, <input type="checkbox"/> swollen, <input type="checkbox"/> mucus discharge <input type="checkbox"/> light hurts eyes				
Ears			<input type="checkbox"/> itchy, <input type="checkbox"/> frequent infections (# __/yr)				
Nose			<input type="checkbox"/> stuffy, <input type="checkbox"/> itchy, <input type="checkbox"/> sneezing, <input type="checkbox"/> runny, _____ color, <input type="checkbox"/> snoring, <input type="checkbox"/> mouth breathing				
Sinus			<input type="checkbox"/> frequent sinus infections (# __) <input type="checkbox"/> thick discharge, yellow/green <input type="checkbox"/> headaches				
Throat			<input type="checkbox"/> post nasal drip, <input type="checkbox"/> sore, <input type="checkbox"/> itchiness, <input type="checkbox"/> throat clearing, <input type="checkbox"/> difficulty swallowing				
Chest			<input type="checkbox"/> cough, <input type="checkbox"/> wheezing, <input type="checkbox"/> shortness of breath, <input type="checkbox"/> bronchitis, <input type="checkbox"/> pneumonias				

System	No	Yes	Check all that apply	Age of onset	All-year or seasonal?	Indoor or outdoor?	Comments
Abd/GI			<input type="checkbox"/> frequent diarrhea, <input type="checkbox"/> vomiting <input type="checkbox"/> reflux, <input type="checkbox"/> food allergies				
Skin			<input type="checkbox"/> eczema, <input type="checkbox"/> hives, <input type="checkbox"/> dry skin, <input type="checkbox"/> dry patches, <input type="checkbox"/> frequent infections				
General			<input type="checkbox"/> weight loss <input type="checkbox"/> failure to gain weight				
Other			<input type="checkbox"/> other infections requiring antibiotic therapy				

**4. DIETARY HISTORY/FOOD REACTIONS:**

- *If patient is a child, is or was the patient exclusively breastfed?* \_\_\_\_\_  
for how long? \_\_\_\_\_
- *When was formula introduced?* \_\_\_\_\_  
*Which formula?* \_\_\_\_\_  
*Reactions?* \_\_\_\_\_
- *Do you have any special diet?* \_\_\_\_\_
- *Are you avoiding any foods?* \_\_\_\_\_

FOOD	AGE	SYMPTOMS/REACTIONS	STILL AVOIDING?

**5. PRECIPITATING FACTORS/TRIGGERS: Please check boxes**

	Yes	No		Yes	No
Tree exposure			Tobacco smoke		
Grass Exposure			Exercise		
Raking leaves/mowing lawns			Animals (cats, dogs, etc.)		
Damp areas with mold and mildew			Cold or hot water		
Sweeping, dusting, vacuuming			Colds (upper respiratory infections)		
Smog/air pollution			Cleaning agents, fumes, perfumes		
Aspirin/Ibuprofen/other drugs			Menstrual periods		
Nighttime			Insect stings		
Temperature changes (hot/cold)			Others:		
Itchy lips/throat after eating bananas, melons, peaches, apples, kiwi, pears, citrus, shellfish, peanuts, or tree nuts					

**6. PREVIOUS ALLERGY EVALUATION AND TREATMENT:**

- *Have you ever had allergy skin testing?*  Yes  No *Date:* \_\_\_\_\_ *Physician:* \_\_\_\_\_  
*Results:* \_\_\_\_\_
- *Have you ever had RAST testing (blood test)?*  Yes  No *Date:* \_\_\_\_\_ *Physician:* \_\_\_\_\_  
*Results:* \_\_\_\_\_
- *Have you ever received immunotherapy (allergy shots)?*  Yes  No  
*Date:* \_\_\_\_\_ *Physician:* \_\_\_\_\_

• *Have you ever used:*

- Nasal Sprays:**    Rhinacort   Flonase   Nasonex
- Inhalers:**        Proventil/albuterol   Flovent   Pulmicort   Advair   Maxair   Intal
- Medications:**    Singular   Claritin   Allegra   Benedryl   Atarax   Prednisone   Prelone

**7. PAST MEDICAL/SURGICAL HISTORY:** *Have you ever had any of the following conditions?*

<p><b>List other medical illnesses:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Cough up blood</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Kidney problems</p> <p><input type="checkbox"/> Snoring/mouth breathing</p> <p><input type="checkbox"/> Diabetes</p>	<p><b>ER/Hospitalizations?</b> When/why</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Abnormal tests?</b></p> <p><input type="checkbox"/> Chest XR, when _____</p> <p><input type="checkbox"/> CT scan</p>	<p><b>Any surgeries?</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Tonsils/adenoids removed, if yes, when? _____</p> <p><input type="checkbox"/> Sinus surgery?</p> <p><input type="checkbox"/> Myringotomy (tubes in ears)?</p>
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**8. MEDICATIONS:** *Do you take any medications currently? Please list all medications and dosages.*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**9. ALLERGIES:** *Do you have any known allergies to medications, foods, or drugs? If so, what was your reaction?* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**10. FAMILY HISTORY:**

Mother's health \_\_\_\_\_ age \_\_\_\_\_    Father's health \_\_\_\_\_ age \_\_\_\_\_

Brother(s) health \_\_\_\_\_ age \_\_\_\_\_    Sister(s) health \_\_\_\_\_ age \_\_\_\_\_

*Do any family members have a history of allergic or immunologic conditions? If yes, please complete all that applies.*

ALLERGY/DISEASE	YES	NO	LIST RELATIVES (INDICATE IF OUTGROWN AND WHEN)
Asthma			
Frequent bronchitis			
Frequent pneumonias			
Cystic fibrosis or other lung disease			
Hay fever / allergic rhinitis			
Chronic sinus problems			
Hives / urticaria			
Eczema			
Insect allergy			
Drug allergy			
Food allergy			
Immune disorder			
Autoimmune disorder (lupus, thyroid disease, rheumatoid arthritis)			
Early unexplained death in infancy			
Other			

11. **ENVIRONMENT/HOME SURVEY:** *List city and states where you have lived, with most recent first.*

City	State	Years	Effects on symptoms, better/worse/no change
1.			
2.			
3.			
4.			

- Approximately how old is your home? \_\_\_\_\_
- How long have you lived there? \_\_\_\_\_
- Is your home a  single family home,  brownstone/townhouse,  apartment?
- Does it have  central air conditioning,  central or forced hot air,  radiator heat,  baseboard,  window air conditioning,  humidifier,  damp areas,  basement,  visible mold,  cockroaches,  smokers?
- Does your bedroom have  wall-to-wall carpeting,  hardwood flooring,  area rugs,  down pillows and/or comforter,  stuffed toys?
- Does your bedroom have  dust mite proof pillow and/or mattress covers,  HEPA filter,  weekly washing of bed linens?
- Please list all fur-bearing pets (cats, dogs, birds, gerbils, hamsters, etc.)  
\_\_\_\_\_
- Do the pets enter your bedroom? \_\_\_\_\_ bed? \_\_\_\_\_
- Is there any location where your symptoms are worse? \_\_\_\_\_
- What is your occupation? \_\_\_\_\_ Are your symptoms worse at work? \_\_\_\_\_
- How many days from school or work have you missed because of your asthma or allergies? \_\_\_\_
- Smoke exposure:     **Yes**     **No**    Where? \_\_\_\_\_

12. **IMMUNIZATIONS:** *Please list vaccinations which you have received within the last 5 years.*

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# Lisa Barisciano, M.D.

Pediatric and Adult Asthma, Allergy & Immunology, LLC

<input type="checkbox"/> New <input type="checkbox"/> Update Information	
Name of PCP:	

Registration Form

<b>FOR REFERRALS</b>
Referring Physician:
Address/phone:

PATIENT NAME (Last, First, MI)			TELEPHONE (Home)			TELEPHONE (Mobile or Other)			
E-MAIL Address			EMPLOYER NAME			TELEPHONE (Work)			
ADDRESS			EMPLOYER ADDRESS						
CITY		STATE	ZIP		CITY		STATE	ZIP	
DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NUMBER			EMPLOYMENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Employed		PATIENT STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a Student		
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		AGE		EMERGENCY CONTACT Name: _____ Relationship: _____				Phone: _____ Cell Phone: _____	

### RESPONSIBLE PARTY FOR BILLING (IF DIFFERENT THAN PATIENT)

RESPONSIBLE PARTY NAME (Last, First, MI)			SOCIAL SECURITY NUMBER		PATIENT RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child   Other: _____			
RESPONSIBLE PARTY ADDRESS (Street, Apt.No.)			EMPLOYER NAME			TELEPHONE (Work)		
CITY		STATE	ZIP		EMPLOYER ADDRESS (Street, Apt. No.)			
TELEPHONE (Home)		TELEPHONE (Emergency)			CITY		STATE	ZIP

### INSURANCE

PRIMARY INSURANCE IN WHOSE NAME?			DATE OF BIRTH		PATIENT RELATIONSHIP TO INSURED PARTY <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child   Other: _____			
PRIMARY INSURANCE CARRIER		TELEPHONE	GROUP NUMBER		POLICY ID NUMBER		Does your primary insurance require a referral to see a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECONDARY INSURANCE IN WHOSE NAME (As on ID card)?			DATE OF BIRTH		PATIENT RELATIONSHIP TO INSURED PARTY <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child   Other: _____			
SECONDARY INSURANCE CARRIER		TELEPHONE	GROUP NUMBER		POLICY ID NUMBER		Does your secondary insurance require a referral to see a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**The undersigned patient or individual acting on behalf of the patient agrees as follows:**

1. I authorize Lisa Barisciano, MD to render needed treatment to the above named patient.
2. I authorize Lisa Barisciano, MD to release any medical or other information, as required in the course of examination or treatment, to process patient's claims. I also request payment of government benefits to either Lisa Barisciano, MD, who accepts assignment, or myself.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician. I understand that I am responsible for charges not covered by my insurance.
4. I understand that I am responsible for all charges incurred through Lisa Barisciano, MD. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. In Medicare assigned cases, Lisa Barisciano, MD agrees to accept charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT/LEGAL SIGNATURE

DATE

1 \_\_\_\_\_