WELCOME TO OUR PRACTICE

Our goal is to provide you the best possible medical care in a courteous and efficient manner. Our doctors were awarded "Top Docs" in their specialty by Northeast Ohio Magazine 2002.

Please complete the following information and return it to us before your appointment. ***You can mail it to: Allergy & Asthma Center of NE, OH, Inc.,*** *215 West Bowery St. Suite 4500, Akron, OH 44308* ***or you can fax your information to us at 330-762-2988. Please check that you have checked all the following information before you send this back to us:***

The date and time of your appointment is ________________________________ with
Rajeev Kishore, MD   Ravi M. Karnani, MD   Nancy Wasserbauer, DO   Mary George, NP

☐ Please attach a copy of your current insurance card, front and back. Do not send your original insurance card please. ***Make sure you bring your insurance card at each visit.***

☐ Complete the enclosed registration sheet front and back. You need to sign the financial policy. **Note: Testing may take 1-2 hrs.**

☐ Please check with your insurance company to make sure we are contracted with them.

☐ Medicaid patients need to send a copy of their current Medicaid card, front and back.

☐ Co-pays, deductibles and coinsurances are due at the time of service in our office. We accept MasterCard, Visa, Discover, cash, money order or checks as payment in our office. If we are not contracted with your insurance, payment in full is due at the time of service. We offer the services of our billing department specialists for payment options upon request.

☐ Cancellations – if you are not able to keep your scheduled appointment, please call as soon as possible to reschedule or cancel. For your convenience you can leave a message on our cancellation line. The number for cancellations is 330-762-7475 , option #6. Between 12:00 to 1:30 pm and after 4:30 pm you can leave cancellations on our billing number: 330-315-0918 or after hours by on extension #213.

☐ **Please check the attached information sheet regarding medications that need to be held for a week prior to skin testing**. Please do not hold medications that are used for any medical condition other than allergies. If you are having an increase of symptoms or acutely ill at the time of your appointment, we do not want you to hold any of your medications.

☐ Please do not wear perfumes, hair sprays, body lotions, colognes or other types of scented items to our office. Many of our patients are very sensitive to those items and exposure to these may cause some of our patients to become ill. We also do not allow food or beverages in our office because of our patients with food allergies.

Please call us if you have any questions regarding the above information. Thank you.

NEW PATIENTS ARE REQUIRED TO ARRIVE 20 MINUTES EARLY

ALLERGY AND ASTHMA CENTER OF NORTHEAST OHIO, INC.

Rajeev Kishore, MD, Ravi M. Karnani, MD, Nancy Wasserbauer, DO, Mary George, NP

PLEASE COMPLETE AND MAIL BACK TO OUR OFFICE

Date and time of appt

PATIENT INFORMATION

Have you ever been seen by one of our doctors or our nurse practitioner? ☐ Yes ☐ No | In Year: | Physician Name:

Patient Last Name Name	First Name	Middle	Birth date:	Age:	Sex: ☐ M ☐ F
Patient's Street Address:			City	State	Zip Code

Home Phone Number with area code:	Alternate Phone Number: ☐ Neighbor ☐ Friend ☐ Family ☐ Cell phone ☐ Pager
Patient employment	Name for alternate phone number if neighbor, family or friend
Employment address	Employment phone number
Marital Status:	Patient social security no: / E-mail address

PLEASE FILL OUT THIS SECTION IF PATIENT IS UNDER 18 YEARS OF AGE or Covered under parent's insurance
Please note: the person bringing the patient to our office is responsible for payment

Mother's Full Name	Mother's Birth date:	Mother's Social Security:	Marital Status:
Mother's employer	Employer's address		Employer's phone number:
Father's Full Name	Father's Birth date:	Father's Social Security:	Marital Status:
Father's employer	Employer's address		Employer's phone number:
Other (step parent, legal guardian, etc.)	Birth date:	Social Security:	Relationship to patient:
Employer:	Employer's address		Employer's phone number:

IF PATIENT IS COVERED UNDER A SPOUSE'S INSURANCE, COMPLETE THIS SECTION

Spouse's Full Name:	Spouse's Birth date:	Spouse's Social Security:	
Spouse's Employer:	Employer's address:		Employer's phone number

INSURANCE COVERAGE – PLEASE ATTACH A COPY OF YOUR INSURANCE CARD(S) FRONT AND BACK
If your insurance(s) requires a referral, please have a copy of the referral faxed to us at 330-762-2988-we must have a written copy in our office the day of your appointment!

Primary Insurance Coverage	Insurance Company Name	Policy or ID number	Group number	
	Insurance mailing address	City	State	Zip Code
	Policy holder's name	Relationship to patient	Policy holder's birth date	
	Insurance phone number	Is a referral required? ☐ Yes ☐ No	Did you contact your PCP for referral? ☐ Yes ☐ No	
Secondary Insurance Coverage	Insurance Company Name	Policy or ID number	Group number	
	Insurance mailing address	City	State	Zip Code
	Policy holder's name	Relationship to patient	Policy holder's birth date	
	Insurance phone number	Is a referral required? ☐ Yes ☐ No	Did you contact your PCP for a referral? ☐ Yes ☐ No	
Tertiary Insurance Coverage	Insurance Company Name	Policy or ID number	Group number	
	Insurance mailing address	City	State	Zip Code
	Policy holder's name	Relationship to patient	Policy holder's birth date	
	Insurance phone number	Is a referral required: ☐ Yes ☐ No	Did you contact your PCP for a referral? ☐ Yes ☐ No	

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name:	Address:	Phone Number:

ALLERGY AND ASTHMA CENTER OF NORTHEAST OHIO
FINANCIAL POLICY

Our policy is that payment is due at the time of service. We accept cash, check, money order, Visa, MasterCard, Discover and Debit cards.

Contracted Insurances	We do have contracts with most insurance companies. Please check with your insurance company to see if we are part of their network. It is your responsibility to make sure that we are in your insurance network.
Co-payment Deductibles coinsurance	We require payment for all co-pays, deductible and coinsurance the day of service. Any balance left after your insurance pays their portion is due from you. **If your co-pay is not paid by you on the day of service you will be assessed a $10.00 administrative charge if we have to bill you for the copay.**
Admin. Charges	There is a **$10.00 administrative charge monthly if we have to send out a second statement** for a balance due from you. We will bill you after your insurance pays. You are required to pay the balance when you receive our first statement.
Referrals	It is the **patient's responsibility to make sure they have a valid authorization if required** from their primary care physician at the time of service. We will assist you if possible to obtain referrals. If we do not have a valid referral in our office at the time of the appointment, the patient will be responsible for payment for those services.
No show	**We may assess a $25.00 fee for appointments** that are not canceled 24 hours before a scheduled appointment. If you are unable to keep a scheduled appointment, you need to cancel as soon as possible. We have a cancellation line available to leave messages about cancellations.
Insurance Payments	If we have not received payment from your insurance company within 60 days from the date you were seen, we will send you a statement. **You are responsible to send any information required by your insurance company to process the claim.** If the requested information is not sent to your insurance company, you will be responsible for the charges and administrative fees may be applied to your account.
Billing Statement	**Billing statements are sent out on the 1st of each month. Payment is due in full upon receipt and needs to be paid before the next billing cycle.** Partial payments will incur billing fees for each month there is a balance unless you have contacted our billing department and made arrangements beforehand. We understand that unforeseen circumstances can sometimes occur that interfere with a patient's ability to pay for their services. In the event of such circumstances we would request that you discuss such problems with out billing department. The direct phone number is 330-315-0918.
Medicaid	Patients on Medicaid insurance plans **need to bring their current Medicaid/insurance card with each visit or service**. Per our agreement with Medicaid, no routine visits or injections can be performed without a valid Medicaid/insurance card.
Insurance Cards	We will need to **see your insurance card each time you come to the office**. Group numbers and mailing addresses change frequently for insurances and we need to have the most current information in order to get reimbursed for services rendered. We may not be able to see you in our office if you do not have your insurance card.
Divorced Parents	It is our policy that the **parent accompanying the child for treatment is responsible for payment**. Payment of any balances or copays are due at the time of service.
Outstanding Balances	**Any outstanding balance that has not been settled after reasonable attempts for payment will be sent to a collection agency for payment**. If that occurs you will be dismissed from our practice.
Postage fees	Due to the rising costs of mailing, faxing, transcribing and the cuts in insurance reimbursements we regrettably can no longer absorb the cost for postage. Please send in a self addressed, stamped envelope if you are requesting forms or prescriptions by mail from our office or arrange for pick-up, otherwise there is a $2.00 fee. There is a $3.00 charge for allergy vaccine mailing.
Minors	We require that all patients under the age of 18 have a parent or legal guardian with them in order for them to be seen in our office. This includes allergy injection patients.
NSF check	If your check is returned for nonsufficient funds (NSF), your account will be debited electronically for both face amount & returned check fees. You are responsible for any fees incurred by our office to obtain payment for your NSF check

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY

A. I have read, understand and agree to the above financial policy.

B. I hereby authorize the physicians and practitioners of Allergy & Asthma Center of NE Ohio to evaluate and treat myself or my dependents as medically necessary.

C. I hereby authorize Allergy & Asthma Center of NE Ohio to furnish information requested to insurance companies concerning illness and treatment in their office.

D. I hereby assign insurance payments directly to the physicians/practitioners of Allergy & Asthma Center of NE Ohio for any medical services rendered to myself or my dependents in their office or ancillary facilities.

Patient or Responsible Party:____**Date:** ______________________________

ALLERGY & ASTHMA CENTER OF NORTHEAST OHIO

215 W. Bowery St., Suite 4500, Akron, OH 44308 330-762-7475
Rajeev Kishore, MD, Ravi M. Karnani, MD, Nancy Wasserbauer, DO Mary George, RN, MSN, CNP

ALLERGY TESTING

In order to do allergy testing, antihistamines need to be stopped prior to the testing. Decongestants do not have to be stopped, but many products combine them with antihistamines. If you are not sure, do not take the medicine.

DO NOT STOP ANY ASTHMA MEDICATIONS
DO NOT STOP ANY HEART, DIABETES, HIGH BLOOD PRESSURE, ANTIBIOTICS OR OTHER MEDICATIONS FOR CHRONIC CONDITIONS.

Stop these antihistamines 5 – 7 days prior to the testing appointment: Alavert/ Claritin (Loratadine) Clarinex Allegra (Fexofenadine) Xyzal Zyrtec Aller-Chlor, C.P.M., Chlo-Amine, Chlor-Allergy, Chlor-Mal, Chlor-Trimeton, Chlorphen (Chlorpheniramine) Allerhist-1, Contac 12 hr Allergy, Tavist -1(Clemastine) Periactin Atarax. Rezine (Hydroxyzine) PBZ & PBZ-SR (Tripelennamine) Phenergan Promethazine Prorex	Stop other prescription antihistamines 3-5 days prior to testing, such as: Extendryl — Actifed Sinus Day AllerX — Aler-Dryl Tussi products (pyrlamine) — Benadryl Comtrex — Calm-Aid Rynatan — Compoz Nighttime Unisom — Diphedryl Benadryl (Diphenhydramine) — Diphen-Allergy Duradryl/Rondec — Genahist Semprex — Hydramine Tylenol PM — Nytol Tanafed — Scot-Tussin Allergy Polaramine — Sominex Tylenol PM — Twilite Unisom Sleepgels
Stop "Over the Counter" antihistamines 48-72 hours prior to the testing, such as: Dimetapp (Brompheniramine) Bonine (Meclizine) Triaminic Dimetapp Products Pediacare Products Any product with: Carboximine Triprolidine HCL Dosylamine succinate Drixoral (Dexbrompheniramine)	Stop Allergy specific eye drops 24 hours prior to testing: Visine-A — Optivar Zaditor — Elestat Alaway — Vascaon Patanol — Opticon Pataday — Livostin **DO NOT STOP ANY EYE DROP FOR OTHER EYE CONDITIONS SUCH AS GLAUCOMA OR INFECTIONS**
DECONGESTANTS THAT MAY BE TAKEN ARE: **Sudafed – Pseudoephedrine** **Afrin Nasal products** **Neosynephrine nasal products** **Phenylephrin**	Stop **antihistamine** nose sprays 24 hours prior: Astepro Astelin Patanase **Corticosteroid nose sprays do not need to be stopped**

ALLERGY & ASTHMA CENTER OF N.E. OHIO, INC.

PATIENT QUESTIONNAIRE ***Please return prior to appointment***

NAME____BIRTHDATE__________ AGE________SEX________

APPT. DATE_____________REFERRED BY ___________________PRIMARY CARE______________________

A. Briefly describe the reason for your visit ____

____

____

B. MEDICATIONS CURRENTLY TAKING AND DOSAGE

1 ____________________________________ 5 ____________________________________

2 ____________________________________ 6 ____________________________________

3 ____________________________________ 7 ____________________________________

4 ____________________________________ 8 ____________________________________

Have you used nasal sprays ÿ YES ÿ NO If yes, name: ____________________________________

Have you taken cortisone (steroids)? ÿ YES ÿ NO If yes, when? ______________________________

Have you used antihistamines? ÿ YES ÿ NO If yes, name: ________________________________

Do you have a nebulizer/aerosol machine? ÿ YES ÿ NO

C. MEDICATION REACTIONS: List any medication allergy or reaction below:

Medication	Approximate Date	Symptoms
For Infants: Formula's using/used		

D. SYMPTOMS: Do you experience any of the following: (Check each box that applies)

	NOSE:		SINUS:		CHEST:		SKIN:
	Stuffy		Headaches		Tightness		Rash
	Sneezing		Sore throats		Wheezing		Hives
	Itching/rubbing nose		Post nasal drainage		Wheezing when exposed to dust, pollen, animals, etc.		Eczema
	Clear/colorless discharge		Throat clearing/sniffing		Wheezing with colds/infections		Swelling
	Thick/colored discharge		Hoarseness		Wheezing/cough after exercise		Itching
	Mouth breathing		Bad breath		Shortness of breath		Sores
	Snoring		Frequent infections		Productive cough		What area?
	Loss or decreased sense of smell		EAR:		Dry cough		OTHER:
	Nose bleeds		Itching		Bronchitis		Fatigue
	EYE:		Full/popping				
	Red		Painful				
	Itchy		Ringing/hearing loss				
	Watery		Frequent infections				
	Dark circles/puffiness						

E: TRIGGERS OF YOUR SYMPTOMS:

Are your symptoms ÿ Year Round ÿ Seasonal ÿ Both

During what months do you usually have symptoms: ________________________________

Which of the following cause your symptoms or make your symptoms worse: (Check each box that applies)

	Mowing lawn/yard work		Weather change		Perfume		Morning
	Vacuuming/house dust		Wet weather		Chemical fumes		Afternoon
	Cedar		Dry weather		Smoke		Night
	Pollen		Windy day		Cleaning agent		Alcohol
	Mold or mildew		Hot day		Newspaper		Beer
	Damp areas		Cold day		Indoors		Wine
	Dogs		Air-conditioning		Outdoors		Stress
	Cats		Air pollution		At home		Other
	Other animals				At work		

F. DURATION/SEVERITY OF SYMPTOMS:

Have your symptoms been present: ÿ all our life? ÿ _______ months/year? Are your symptoms:

	Mild		Rare		Interfering with your life
	Moderate		Frequent		Preventing many normal activities
	Severe		Constant		

G. FOOD REACTIONS:

Have you ever had any ***systemic symptoms*** (itching, hives, wheezing, shortness of Breath, throat swelling, dizziness, fainting, shock) after ingestion of food or liquid ÿ YES (If yes specify↓): ÿ NO

____

____

____

Do you have any ***intestinal symptoms*** (nausea, vomiting, cramps, pain, diarrhea) after ingestion of food Or liquid? ÿ YES ÿ NO If yes: specify: ____________________________________

____

____

____

For infants – ***current formula***____

H. HOME ENVIRONMENT:

Do you live in a: ÿ House ÿ Apartment ÿ Condominium ÿ Mobile Home ÿ Single ÿ Two Story

How long have you lived there? _______years/months Age of home: ______ years

Is it located on/near: ÿ Water ÿ Vacant land ÿ Industrial area ÿ Farm

Air conditioning: ÿ Central ÿ Window ÿ None Ceiling fans: ÿ YES ÿ NO

Type of flooring: ÿ Carpet ÿ Wood ÿ Tile ÿ Vinyl ÿ Other

ÿ Throughout ÿ In bedrooms ÿ Living room

How old is your mattress? ___________Type of Mattress: ÿ Inner spring ÿ Water ÿ Allergy encasing

How old is your pillow? _____________ Type of Pillow: ÿ Feather ÿ Synthetic ÿ Foam ÿ Allergy encasing

Do you have pets? ÿ YES ÿ NO If yes, list the number and kind (i.e. dog, cat, bird, etc.)

____

Are your allergy/asthma symptoms worse around your pets? ÿ YES ÿ NO

Do your pets live: ÿ Indoors ÿ Outdoors ÿ Both?

Do your pets sleep in your bedroom? ÿ YES ÿ NO Do your pets sleep on your bed? ÿ YES ÿ NO

I. WORK ENVIRONMENT:(as applies to patient)

What is your occupation? _______________________ Where are you employed? ________________

How long have you worked there? ___________Is your environment ÿ Carpeted ÿ Tiled ÿ Other

Is it air conditioned? ÿ YES ÿ NO Is smoking permitted? ÿ YES ÿ NO

Are you exposed to chemicals or strong odors? ÿ YES ÿ NO
If yes, please specify: ____

Are your symptoms worse at work? ÿ YES ÿ NO If yes, please specify: ______________________

Have you missed time from work because of allergies? ÿ YES ÿ NO If yes, how much time? _________
Comments: ____

J. SCHOOL HISTORY/ENVIRONMENT: (as applies to patient)

Do you attend school? ÿ YES ÿ NO If yes, what grade level? ______________________

Is your classroom: ÿ Carpeted ÿ Tiled ÿ Other / Any animals in your classroom? ÿ YES ÿ NO

Do you participate in physical education? ÿ YES ÿ NO

Have you missed time from school because of allergies/asthma? ÿ YES ÿ NO
If yes, how many days missed last year? __________ Comments: ______________________________

K. PAST MEDICAL HISTORY:

Birth weight _____________________ Born at term? ÿ YES ÿ NO If no, how early? ___________
Problems with pregnancy or delivery? ____

PLEASE LIST ANY SURGERIES/HOSPITALIZATIONS/MEDICAL CONDITIONS BELOW:	DATE:

ANY LAB TESTS/X-RAYS RELATED TO YOUR SYMPTOMS:	DATE:

Are immunizations up to date? ÿ YES ÿ NO

Is growth normal? ÿ YES ÿ NO

Is development normal? ÿ YES ÿ NO At what age level does the child function? ________________

L. SYSTEMS REVIEW: Do you have recurrent or chronic problems with any of the following? Check if yes

	Frequent headaches		Chest pain		Heartburn
	Vision disturbances		Pneumonia		Constipation
	Wear glasses		High blood pressure		Diarrhea
	Wear contacts		Rapid heart beat		Frequent/painful urination
	Frequent colds #_____per yr		Nausea/vomiting		Arthritis

M. SMOKING:

Do you presently smoke? ÿ YES ÿ NO If yes, average number of cigarettes per day: _____________
IF yes, when did you start? ______________

Have you ever smoked? ÿ YES ÿ NO If yes, how many years? __________When did you stop? _______
Average number of cigarettes you smoked per day? ____________

Does anyone smoke in your home? ÿ YES ÿ NO If yes, who? _________________________________

N. FAMILY HISTORY:

List family members who have a history of any of the following illnesses: check the boxes below:

		List family member			List family member
	Hayfever/Allergy			Headaches	
	Asthma			Cancer	
	Eczema			Diabetes	
	Hives			High blood pressure	
	Swelling			Heart attack	
	Food allergy			Cystic Fibrosis	
	Immunodeficiency			Emphysema	
	Tuberculosis			Recurrent bronchitis/pneumonia	

O.ANY ADDITIONAL INFORMATION YOU NEED TO TELL US?____________________