88

Please print this form, complete it, and bring it to your visit.

Allergy & Asthma Care of New York

Midtown Office
425 Madison Avenue
11th Floor
New York, NY 10017
Tel: 212-759-8644

Gramercy Park Office
381 Park Ave South,
Suite 1020
New York, NY 10016
Tel: 212-260-6078

Financial District
150 Broadway,
Suite 1601
New York, NY 10038
Tel: 212-964-1295

Upper East Side Office
201 East 65th Street,
New York, NY 10065
Tel : 212-260-6078

Patient Insurance Questionnaire

Patient's Name: ____________________
Street Address: ____________________
City: ____________________
State: __________ Zip: __________
Social Security Number: ____________________

Date of Birth: __________ Age: _______
Telephone (Home): ____________________
Telephone: (Work): ____________________
Cell Phone/Pager: ____________________
Email Address: ____________________

Occupation: ____________________
Patient's Employer/Address: ____________________
Referring Physician/Address: ____________________
Additional Physician Reports to: ____________________
Sex: [ ]Male [ ]Female Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widow
Chief complaint: ____________________
Other Referral Sources: ____________________
Emergency Contact: ____________________ ____________________

PRIMARY INSURANCE (copy of insurance card is required)	SECONDARY INSURANCE (copy of insurance card is required)
Name of insurance company: __________	Name of insurance company: __________
Address: __________	Address: __________
ID or Policy #: __________	ID or Policy #: __________
Group #: __________	Group #: __________
Effective date of insurance: __________	Effective date of insurance: __________
Who is Subscriber: (check one)	Who is Subscriber: (check one)
[ ]Self [ ]Spouse [ ]Parent [ ]Other: __________	[ ]Self [ ]Spouse [ ]Parent [ ]Other: __________
If Subscriber is other than Self, complete following:	If Subscriber is other than Self, complete following:
Subscriber's name: __________	Subscriber's name: __________
Sex: [ ]Male [ ]Female	Sex: [ ]Male [ ]Female
Address: __________	Address: __________
Date of birth: __________	Date of birth: __________
Social security number: __________	Social security number: __________

AUTHORIZATION INFORMATION (Assignment of Benefits)

I hereby assign to ____________________any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arraignment, payment to the practice will be made by any insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except where prohibited by contract). I also understand that in the event that services rendered are not covered under by "insurance" I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to remake payment, in full, for the services rendered to me (depending upon the assignment) at the time.

Signature: ____________________
Date: ____________________

FOR RELEASE OF INFORMATION

I authorize the release of any medical information or other information as is necessary to process this claim based

upon the HIPAA Notice of Privacy Practices, informaiton provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature: ______________________________

Date: ______________

Patient Health Questionnaire

Patient Name:__________________________Age:_____

Male:___Female:___Date:__________

Referring Physician/Address/Phone:____________________________

____

____

Why are you seeing us? (Please describe.):____________________

____

____

____

1. DO YOU HAVE ANY OF THESE?	**YES**	**NO**
Nasal congestion and/or runny nose	___	___
Itchy or w atery eyes	___	___
Frequent sneezing	___	___
Snoring	___	___
Drainage dow n back of throat	___	___
Frequent yellow or green nasal drainage	___	___
Frequent headache	___	___
Coughing	___	___
Wheezing or shortness of breath	___	___
Diagnosis of asthma	___	___
Past hospitalization for asthma	___	___
Possible reaction to food or drug	___	___
Bee sting reactions	___	___
Rashes or eczema	___	___
Frequent sinus infections/bronchitis	___	___

Comments:_________________________________

2. SYMPTOMS OCCUR MOST OFTEN:

Spring___ Summer___ Fall___ Winter___ Year round___

3. SYMPTOMS WORSEN/CHANGE WITH:

___Cold air
___Cigarette smoke
___Chemicals
___Aerosols sprays
___Cosmetics
___Plants (poison ivy)
___Dusting or cleaning
___Colds/flu
___Pets (cat, dog, bird, other)
___Fresh cut grass
___Raking leaves
___Weather change
___Exercise
___Sunscreens

4. LIST YOUR CURRENT MEDICATIONS	# or mg tabs, caps or inhaler puffs	Times per day
___________	___________	________
___________	___________	________
___________	___________	________
___________	___________	________

5. TELL US ABOUT YOUR HOME ENVIRONMENT:

Type of house/apt floor: _____________________ Length of occupancy: __________

HEAT: ___Radiator ___Central ___Hot Water

A/C: ___Central ___Window ___None

HUMIDIFIER: (central/separate units)_____________________________

Dampness/musty areas: ___Yes ___No

BEDROOM: Type of comforter/duvet_____________________________

Type of blankets:____
Type of pillows: ___Feather ___Foam
FLOORING:(tile/wood/carpet) Living area__________________ Bedroom__________________
TYPE & # of Pets:__________________________ Bedroom pets:________________________
Previous pets:____Mice/roaches: ___Yes

7. HOSPITAL VISITS/SURGERIES: ____
____

8. IMMUNIZATION STATUS: Are your vaccines up-to-date? ___Yes ___No
Describe:____

9. PAST ALLERGY CARE: ____

10. DO YOU HAVE ALLERGIC REACTIONS TO:
Aspirin: _________________________
Sulfites: _________________________
Medications: ______________________
Foods & additives: __________________
Insect stings: ______________________
Plants: _______________________________
Soaps/fabric softeners/cosmetics: ____________
Latex rubber: __________________________
Vaccines: _____________________________
Other: _______________________________

11. FAMILY HISTORY: Parents:____
Siblings:___________________________________ Other: ____________________

12. SOCIAL & WORK HISTORY: Occupation:___________________________________
Work exposure: ____
Skin sensitivities: ____
Sensitivity to chemicals/smells/newspapers: _____________________________________
Alcohol usage: ____
Drug usage: ____
Tobacco history: ___Yes ___No Please describe: _______________________________
Secondary tobacco exposure: ____