ALLERGY & IMMUNOLOGY

HEALTH SERVICES

John A. Panuto, M.D. - ***Board Certified***

Dear Patient,

Enclosed are your New Patient Forms.

If your insurance requires a referral, please make sure this has been called into your primary care physician. If you do not have this information on the date of your visit, your appointment may need to be rescheduled.

To be tested, please note: **You must not be on any antihistamines anywhere from 48 hours to 1 week prior to your appointment.** ***(See attached antihistamine list to verify)***.

Medications do not have to be stopped if coming in for hives. Asthma medications can be continued. Please check with our office if you are unsure.

Thank you for your consideration. We look forward to seeing you in our office.

Note:

Please complete your forms and bring them with you on the date of your visit along with your insurance card and a list of your current medications. Co-pays are required to be paid at time of visit.

(Do not mail in paperwork. Bring with you to your office visit.)

Thank you,

Allergy & Immunology Health Services

25761 Lorain Road, 3rd Floor
North Olmsted, Ohio 44070-3327
(440) 779-1112
Fax (440) 779-0247

15299 E. Bagley Road, Suite 300
Middleburg Hts., Ohio 44130-4892
(440) 234-5150
Fax (440) 887-7613

252 East Broad Street
Elyria, Ohio 44035-6433
(440) 329-7760
Fax (440) 322-4097

Allergy & Immunology Health Services

GUIDELINES FOR AVOIDING ANTIHISTAMINES PRIOR TO ALLERGY SKIN TESTING

Antihistamines must be discontinued prior to skin testing. Some antihistamines should be discontinued 48 hours prior to testing and some (as listed) need to be discontinued up to a week prior to testing. Decongestants without antihistamines can be taken up to the time of testing.

Please see the following list for some of the most common medications and when they should be discontinued.

If you have any questions about antihistamines in your medication, please check with your physician or your pharmacist.

TRICYCLIC ANTIDEPRESSANTS (Stop these 1 week before)

Amitriptyline (Endep, Enovil, Elavil, Emitrip)
Amoxapine (Asendin)
Desipramine (Norpramin, Pertofrane)
Doxepin (Adapin, Sinequan)
Imipramine (Janimine, Tipramine, Tofranil)
Limbitrol
Nortriptylline (Pamelor, Aventyl)
Protriptyline (Vivactil)
Seroquel
Trimipgramine (Surmontil)

ANTIHISTAMINES (Stop 48 hours to 1 week before.)

Actidil
Actifed
Alavert – 1 week
Allegra – 1 week
Allegra D – 1 week
Allerest
Allergesic
AllerX
Antivert
Astelin Nasal Spray
Astepro
Atarax – 1 week
Atrohist
Azelastine Nasal
Benadryl
Benylin
Bromfed
Brompheniramine
Carbinoxamine Maleate- 1 week
Cetirizine
Chlor- Trimeton
Chlorpheniramine
Claritin –1 week
Claritin D – 1 week
Clarinex – 1 week
Clemastine Fumarate
Clistin Rondec
Clorpheniramine – 1 week
Comtrex
Contac
Coricidin
Cyclobenzaprine
Cyproheptadine
Deconade
Deconamine
Dexbrompheniramine
Dexchlorpheniramine – 1 wk
Dimetane
Dimetapp
Diphenhydramine
Doxylamine
Dramamine
Drixoral
Dristan
Dymista
Extendryl
Fedahist
Fexofenadine–1 week
Flexeril (Muscle relaxer)
Formula 44
Histex – 1 week
Hydroxyzine – 1 week
Isoclor
Loratadine – 1 week
Naldecon
Olopatadine Nasal
Optimine
Orahist
Ornade
Palgic – 1 week
Pataday Eye Drops – 48 hrs.
Patanase
Periactin – 1 week
Phenergan – 5 days
Polaramine
Polyhistine D
Promethazine
Rondec
Rynatan
Ryna- 12-S
Semprex
Sinutab
Sudafed Plus
Tanafed
Tavist
Triaminic
TussiCaps – 1 week
Tussionex
PennKinetic–1 wk
Vicks Nyquil
Vistaril
Xyzal – 1 week
Zyrtec
Zyrtec D
**Also, over-the-counter combination medications that contain antihistamines.

Rev. 03/2018

Allergy & Immunology Health Services

PATIENT INFORMATION SHEET

(PLEASE PRINT)

Date:_____

Patient's Name _____
Last First Middle Initial

Address _____
City State Zip

Sex (Circle) - Female Male Status (Circle) - Single Married Divorced Widowed

Soc. Sec. #_____ Birthdate _____ Age _____

Home # (_____) _____ Work # (_____) _____ Cell /Other # (_____)_____

e-mail address _____

Pharmacy_____ Phone:_____

What Physician referred you here today: Dr. _____
First Name Last Name

Patient's Primary Care Physician (PCP): Dr. - _____
First Name Last Name

Patient's Place of Employment:_____ or Retired

If minor, who presents with patient today?

Name:_____ Relationship: _____
Last Name First Name

Address: _____ Home # (____)_____ Work # (____)_____

City: _____ Zip: _____

PRIMARY INSURANCE

Insurance Company Name _____

Policy # _____ Group # _____ Ins. Effective as of: _____

Patient's Relationship to Insured: Self Spouse Child Step Child Foster Child Other - _____

Policy Holder's Name _____
Last First Initial

Address _____
City State Zip

Policy Holder's Home # (____) _____ Sex (Circle) - Male Female Birthdate _____

Employer _____ Work Phone (_____) _____

Insured's Social Security # _____

SECONDARY INSURANCE

Insurance Company Name _____

Policy # _____ Group # _____ Ins. Effective as of: _____

Patient's Relationship to Insured: Self Spouse Child Step Child Foster Child Other - _____

Policy Holder's Name _____
Last First Initial

Address _____
City State Zip

Policy Holder's Home # (____) _____ Sex (Circle) - Male Female Birthdate _____

Employer _____ Work Phone (_____) _____

Insured's Social Security # _____

Allergy & Immunology Health Services
AUTHORIZATIONS AND ACKNOWLEDGEMENTS

Consent to Treat:
I give consent and authorization for myself/or dependent to Allergy & Immunology Health Services physicians, nurses or medical assistants to administer such medical care as they deem appropriate. I understand that: A) Absent emergency or extraordinary circumstances, no substantial procedures are performed unless there is discussion of the treatment with the physician or other health professional. B) Each patient or appropriate patient representative has a right to refuse consent for treatment.

Disclaimer:
Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The physicians will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Insured or Self Pay
For Insured: I understand that I am responsible for the terms and conditions of my individual insurance plan. I authorize Allergy & Immunology Health Services to submit any and all health care information to my health care insurer and to take all activities necessary to have my insurance carrier reimburse Allergy & Immunology Health Services for medical services rendered under this consent. I understand that while I have health care insurance, I remain primarily liable for payment of all medical services which are not covered by my insurance under this consent.

For Self-Pay: I understand that I have no health care insurance and I am personally responsible for any and all medical services rendered by Allergy & Immunology Health Services at time of service.

Release of your medical information:

[ ] I do not wish my medical information to be released to any significant other.

[ ] I request and authorize Allergy & Immunology Health Services to review and release my medical information with the following individual. (e.g. Spouse, Parent, Sibling, etc.)

Name: _____ Relationship:_____

May we leave a message at home with a family member on your machine or on your voice mail? [ ] Yes [ ] No

Receipt of Notice of Privacy Practices (Revision 10/21/13):

I have received the Notice of Privacy Practices from Allergy & Immunology Health Services. It is also available on the company website at www.entallergyhealth.com.

I have read and understand the terms above.

X_____
Signature of patient and/or guardian / Date

X_____
Please print name

Allergy & Immunology Health Services
ALLERGY AND ASTHMA HISTORY

DATE: _____ NAME: _____

Home Phone: _____ Work Phone: _____Referred By: _____

Please answer questions by drawing circles around your answers or by filling in the blank spaces.

What type of symptoms are you experiencing?

Nasal Symptoms Sinus Symptoms Asthma Drug Reactions Hives

Food Reactions Insect Stings Eczema Other: _____

Do you live on a farm? Yes No

How many years have you lived at your present home?_____

Circle any of the following present in your home: Cat Dog Humidifier Air conditioner

Have you had skin testing in the past? Yes No

Are you receiving allergy shots? Yes No

NASAL SYMPTOMS

Circle any nasal symptoms you frequently experience:

Sneezing Itching Congestion Clear drainage

Yellow drainage Bleeding Loss of sense of smell

What was your age when nasal symptoms started?_____

Is sleep disturbed by nasal congestion? Yes No

Do you have sinusitis? Yes No

Have you taken antibiotics for sinusitis? Yes No

Have you had x-rays of your sinuses? Yes No

Have you had nasal polyps? Yes No

Allergy & Immunology Health Services
ALLERGY AND ASTHMA HISTORY

Do you have headaches more than once a week? Yes No

Do you have facial pain? Yes No

EYE SYMPTOMS

Circle any symptoms which occur frequently:

Itching Watering Burning Dryness Loss of vision Eyelid swelling

EAR SYMPTOMS

Circle any symptoms which occur frequently:

Itching Pressure Pain Ringing Loss of hearing Infections

SYMPTOM PATTERNS

If you have symptoms of the nose, eyes and ears. Circle any factors which make you feel worse:

Spring Summer Fall Winter Off and On all year Constantly

If you have symptoms of the nose, ears and eyes. Circle any factors which make you feel worse:

Animals House dust Musty odors Cold air Food

Do any relatives have hay fever? Yes No

ASTHMA HISTORY

Circle chest symptoms you have had in the past 4 weeks:

Cough Wheeze Shortness of breath Chest pain Yellow mucous

Bloody mucous Heartburn

Did you have chest symptoms as a child? Yes No

What was your age when your chest symptoms started? _____

Was a diagnosis of asthma made in the past? Yes No

Do any family members have asthma? Yes No

Have you been in an emergency room for asthma? Yes No

Allergy & Immunology Health Services
ALLERGY AND ASTHMA HISTORY

Have you ever been hospitalized for asthma? Yes No

Ever required intensive care treatment for asthma? Yes No

Ever received corticosteroid pills or shots? Yes No

Ever had an abnormal chest x-ray? Yes No

Date of last chest x-ray:_____

DISEASE ACTIVITY

Number of days per week you have chest symptoms: _____

Number of nights per week that asthma disturbs your sleep: _____

Number of days of work/school missed in the past month: _____

Circle activities that are difficult due to asthma:

Walking Climbing Stairs Running Sports

Do your current medications control your asthma? Yes No

PATTERN OF ASTHMA

Circle the season asthma attacks are most frequent:

Spring Summer Fall Winter All Year

Circle the time asthma attacks are most frequent:

Morning Afternoon Evening Nighttime

Circle the factors that make your asthma worse:

Animals House dust Smoke Cold Air Exercise Infections Pregnancy

What is your occupation: _____

Do you have occupational exposure to chemical or allergens? Yes No

Are your symptoms worse at work? Yes No

Allergy & Immunology Health Services
ALLERGY AND ASTHMA HISTORY

HIVES AND ANGIOEDEMA

Have you had hives (red itchy welts)? Yes No

Have you had dramatic swelling of the lips, eyelids, throat, hands or feet? Yes No

Circle and factors that trigger hives or swelling:

Heat Cold Exercise Sunlight Pressure Foods Medicine Menses Stress

Do any relatives have hives or swelling episodes? Yes No

FOOD ALLERGIES

Circle symptoms which occur after eating a specific food:

Food: _____

Hives Itchy Mouth Swollen Throat Vomiting Diarrhea Asthma Nasal Congestion Shock

MEDICAL HISTORY FORM

Date: _____ Name: _____

Age:_____ How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height:_____ Weight:_____ Have you had any recent testing? CT Scan MRI X-Ray Labs Other:_____

Main reason for today's visit:_____

PATIENT MEDICAL HISTORY:

Y	N		Y	N		Y	N	
SKIN			**LUNG**			**ENDOCRINE**		
☐	☐	Rash	☐	☐	Asthma	☐	☐	Thyroid Disease
☐	☐	Skin Cancer	☐	☐	Emphysema	☐	☐	Diabetes
EAR/NOSE/THROAT			☐	☐	Sleep Apnea	**NEUROLOGICAL/GENETIC**		
☐	☐	Vertigo	☐	☐	Cystic Fibrosis	☐	☐	Migraines
☐	☐	Tinnitus (ringing)	☐	☐	Bronchitis	☐	☐	Meningitis
☐	☐	Allergies	☐	☐	Tuberculosis	☐	☐	Stroke (Mild or Severe)
☐	☐	Hearing Loss	☐	☐	Pneumonia	☐	☐	Fainting Attacks (Syncope)
EYE DISORDERS			☐	☐	Cancer	☐	☐	Down's Syndrome
☐	☐	Glaucoma	**GASTROINTESTINAL**			☐	☐	Parkinson's
☐	☐	Cataract	☐	☐	Acid Reflux (GERD)	☐	☐	Multiple Sclerosis
HEART			☐	☐	Stomach Ulcers	☐	☐	Alzheimer's (Dementia)
☐	☐	Heart Attack	☐	☐	Cancer	☐	☐	Seizures/Epilepsy
☐	☐	Congestive Heart Failure	☐	☐	Crohn/Ulcerative Colitis	☐	☐	Cerebral Palsy
☐	☐	High Blood Pressure	☐	☐	Liver problems	**PSYCHIATRIC**		
☐	☐	Irregular Heart Beat	**RENAL**			☐	☐	Depression
☐	☐	Carotid Artery Stenosis	☐	☐	Chronic Kidney Disease	☐	☐	Anxiety
☐	☐	Lower Leg Vein Clots	☐	☐	Prostate Problems	☐	☐	Bi-Polar
☐	☐	Heart Defects	☐	☐	Bladder Troubles	**OTHER**		
☐	☐	Aneurysm	☐	☐	Kidney Stone(s)	☐	☐	Cancer
☐	☐	High Cholesterol	**MUSCULOSKELETAL**			☐	☐	Menstrual Disorders
			☐	☐	Rheumatoid Arthritis	☐	☐	Bleeding Disorders
			☐	☐	Sjogren Syndrome			
			☐	☐	Systemic Lupus			

Surgeries: _____ Date: _____

Any other pertinent information about you: _____

☐ **REVIEW OF SYSTEMS:** *Negative unless noted otherwise.*

CONSTITUTIONAL
____Fevers/chills/night sweats/ weakness
____Unexplained weight loss/gain

SKIN
____Rash/Change in mole

EARS/NOSE/THROAT/MOUTH
____Difficulty hearing/Ringing
____Hay fever/Allergies

EYES
____Change in vision

CARDIOVASCULAR
____Shortness of breath
____Chest pain/discomfort
____Palpitations

BREAST
____Breast lump/Nipple discharge

RESPIRATORY
____SOB(Shortness of Breath)
____Hemoptysis (Coughing up blood)
____Cough/Wheeze

GASTROINTESTINAL
____Blood in stools
____Nausea/diarrhea/constipation vomiting/heartburn

GENITOURINARY
____Nighttime urination
____Leaking urine
____Unusual vaginal bleeding
____Pain on urination

MUSCULOSKELETAL
____Muscle/joint pain
____Joint swelling

NEUROLOGICAL
____Headaches
____Memory loss
____Paresthesia (Numbness,tingling)

PSYCHIATRIC
____Anxiety/Stress
____Sleep Problems
____Depression
____Mood Swings

BLOOD/LYMPHATIC
____Unexplained lumps
____Easy bruising/bleeding

ENDOCRINE
____Increased thirst
____Increased urine
____Heat/cold intolerance

OTHER
____Concern with sexual function

FAMILY HISTORY

☐ Stroke	☐ Tuberculosis	☐ Breast Cancer	☐ Kidney Disease
☐ Heart Attack/Angioplasty	☐ Asthma/Emphysema	☐ Other Cancer	☐ Nervous Breakdown
☐ Heart surgery	☐ Glaucoma	☐ Colon Polyps	☐ Alcoholism
☐ High Blood Pressure	☐ Arthritis	☐ Thyroid Disease	☐ Migraine Headaches
		☐ Other - explain: _____	

SOCIAL HISTORY

Tobacco: Yes ☐ No ☐ Have you ever smoked? Yes ☐ No ☐

Type and amount _____ Years _____ If stopped, when?_____

Have you tried to stop? Yes ☐ No ☐ Do you wish to stop? Yes ☐ No ☐

Alcohol: Amount (including beer, wine, and liquor) _____

FOR PEDIATRIC PATIENTS ONLY-

Y	N		Y	N	
☐	☐	Immunization status up to date?	☐	☐	Meningitis?
☐	☐	In the presence of second hand smoke?	☐	☐	Seizures?
☐	☐	In a day care setting?	☐	☐	Head trauma?
☐	☐	Bottle fed?	☐	☐	Jaundice at birth?
☐	☐	Facial malformations?	☐	☐	Vision problems?
☐	☐	Developmental delay (motor/speech)?	☐	☐	Low APGAR score?
☐	☐	Low birth weight (<3.3 lbs.)?	☐	☐	IV antibiotics?
☐	☐	Mother's pregnancy normal length?	☐	☐	Cerebral Palsy?
☐	☐	Did mother have an infection during pregnancy?			

Physicians Signature: _____ Date_____

Allergy & Immunology Health Services

PATIENT MEDICATION LIST

(For all patients 18 years of age or over)

Patient Name: _____

Date(s) _____

MEDICATIONS: Please list any known prescriptions and/or over the counter, herbal and vitamin/mineral/dietary/nutritional supplement.

Medication Name	Dosage	Frequency	Route of Administration (Circle)
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection
			Oral, Topical Sublingual, Injection

ALLERGIES/REACTIONS TO MEDICINES: (List Medication & Circle symptoms that occur)

_____

_____

Hives Rash Itching Asthma Shock

Physician Signature: _____

John A. Panuto, M.D.

Date(s): _____

Allergy and Immunology Health Services, Inc.
BILLING/FINANCIAL POLICY
PLEASE REVIEW AND KEEP A COPY

Welcome to Allergy and Immunology Health Services, Inc. We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care. This information was designed to provide our patients with a detailed explanation of our financial policies.

Insurance Coverage- All patients are ultimately responsible for their own bill and a clear understanding of their insurance policy. Patients who have health care coverage are responsible for providing the office with complete and accurate information regarding their insurance. It is the patient's responsibility, not Allergy & Immunology Health Services, to understand the terms of their insurance coverage. This includes but is not limited to: knowing what services are covered (allergy skin testing, etc.), where services can be performed (lab), that their provider is in network, if your employer has any specific guidelines regarding network providers (ex. Accountable Care Organizations), their deductible, co-payment, co-insurance (if applicable), obtaining required referrals. I understand that I remain primarily liable for payment of all medical services which are not covered by my insurance.

Self-Pay patients- Patients without health coverage are expected to pay their bill in full at time of service. For your convenience, we accept Visa, MasterCard, Discover and American Express.

Co-Pays- Any co-payments required by your insurance company are due at the time of service. We are required by the insurance companies to collect co-pays at the time of the visit. We advise patients of this at the time the appointment is made and when confirming the appointment. We may need to reschedule your appointment if you do not have the co-pay at the time of your visit.

Notice of Balance on Account- In an effort to reduce the cost of mailing billing statements we will notify you of your balance due at time of service. This is only a notification of the balance on your account. It gives you the opportunity to pay on the account while you are in the office.

Medicare Policy- Allergy and Immunology Health Services, Inc. accepts Medicare assignment which means that we agree to accept Medicare's allowance on services provided to you. You will still be responsible for your annual deductible, the co-payment, and any non–covered services specified by Medicare. If you carry a supplemental plan to Medicare, please be sure we have your policy information so that a claim can be filed for you.

Medicaid- All Medicaid patients must present a valid card prior to being seen. If the patient wishes to be seen without their validated card, they will be required to make payment in full, before services are rendered.

Minor Patients- It is strongly recommended that the minor's responsible party accompany them in to the office. If this is not possible the adult accompanying the minor is responsible for seeing that our policies are met.

Missed Appointments- We understand that occasionally a patient may run into a situation where they can not make their appointment. We ask that you call to cancel your appointment at least 24 hours in advance, which allows us the ability to use that time for another patient. If there are subsequent missed appointments, you may lose your ability to schedule future appointments with us.

Fees and Services Provided- Charges for services provided are subject to change without notice. Each patient's insurance coverage and financial situation is different. If a patient has a concern regarding what our charge for a service is, it is the patients responsibility to ask prior to the service being performed. Please be advised that in most cases there will be separate charges for each service provided. There will be a charge for the physician's evaluation and then a charge for any other service performed. This may include but is not limited to allergy skin testing, breathing tests, etc. Some services may be performed more than once, for example allergy skin testing is charged per scratch test. The number of skin tests performed can greatly affect the charge from a few dollars to hundreds of dollars.

Completion of forms- The Physicians are often asked to complete a variety of forms outside of their visit. Completing a form requires time from the Physician's day to review the chart and complete the forms accurately. Therefore, we do charge a nominal fee for this service. The fee can range from $10.00-$25.00 depending on the forms, which must be paid prior to the forms being filled out.

(Over)

Medical Records Fee- We are willing to assist patients who require copies of their records. Due to the time and printing involved, we can offer one set of records at no charge. If additional copies of the record are requested there will be a fee of $15.00 per request. (Fee is subject to change)

Pre-certification / Pre-determination- Authorizations from your insurance company to perform a service does not guarantee payment. It means that the insurance company finds the service medically necessary. The charges will be processed according to your policy. If your policy does not cover a specific service, it will be denied even with prior authorization.

Billing Questions- Any questions regarding billing must be directed to the billing department. Please do not ask other staff members (ex. front desk staff, nurses, physicians etc.) regarding the billing of your services. Information provided from sources outside the billing department is not applicable.

Child Custody- The parent or legal guardian that presents the minor for care and authorizes treatment will be the one who receives the bill for services provided and is responsible to see that the balance is paid.

Check Returned for Insufficient Funds- There is a $15.00 fee for checks returned for insufficient funds.

Referrals- If your insurance policy requires a referral, the patient is responsible to see that a referral is obtained and provide that referral to our office. If authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Nonparticipating Insurance Plans- If Allergy and Immunology Health Services, Inc. does not have an existing contract with your insurance plan you will be responsible for the full billed amount. We will not accept the plans UCR (Usual, Customary & Rates).

Balance Due- If the balance remains unpaid your account may be referred to a collection agency. You will be responsible for collection costs which are incurred. If your account is at a collection status we will need the balance paid in full prior to any future visit.

Separate Entities Separate Bills- If your service requires the services of other entities you will receive a bill from each provider of services separately.

Coding of Services- The American Medical Association maintains the codes that are used in physician billing. The codes are placed into categories such as surgery, radiology, pathology, and medicine. The category in which these codes are placed may affect how your insurance plan process your claim. The physician has no control as to what category the codes are placed. The physician must select the code that represents the service they provided.

New or Established patient?- Per AMA coding guidelines a new patient is one who has not received any professional services form the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Other Source of Payment- If your employer or some other entity is paying for your medical services, please be advised that should the employer or other entity not reimburse Allergy and Immunology Health Services, Inc. for the services rendered the patient, parent and or guardian are liable for payment.

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian - Please Print