



Appointment Date: ____/____/____

Time: ____ : ____ a.m. / p.m. Location: Gurnee / Libertyville

Provider:

Welcome to our Practice!

Allergy & Asthma Consultants is dedicated to providing expert diagnosis and treatment of allergies and asthma in children and adults. We partner with our patients to develop individualized treatment plans that optimize quality of life.

Please arrive 15 minutes prior to your first appointment to complete your registration and bring:

- The completed New Patient Enrollment Packet:
 - Patient Registration Form
 - Allergy Survey
 - Notice of Privacy Practices Acknowledgment (HIPAA Form)
- Current insurance card and applicable co-pay for specialist
- Referral form from your physician authorizing allergy testing, if required by your insurance
- List of all current prescription and over-the-counter medications, including dose and frequency
- Relevant medical records including blood test results, radiology reports and previous allergy testing/treatment

AVOID TAKING ANTIHISTAMINES FOR AT LEAST 48 HOURS PRIOR TO YOUR APPOINTMENT

Antihistamines can alter allergy skin testing results. Please continue to take all of your other medications as prescribed, including inhalers. Below is a partial list of the most commonly used antihistamines:

Allegra/Fexofenadine	Benadryl/Diphenhydramine	Dymista Nasal Spray
Astelin/Azelastine Nasal Spray	Chlortrimeton/Chlorpheniramine	Patanase Nasal Spray
Astepro Nasal Spray	Clarinet/Desloratadine	Xyzal/Levocetirizine
Atarax/Hydroxyzine	Claritin/Loratadine	Zyrtec/Cetirizine

Cancellation and No-Show Policy

Our practice prides itself on accommodating the needs of our patients in a timely manner. No-shows or late cancellations of appointments deprive other patients from the opportunity to see our providers and are subject to a \$50 fee. Therefore, if you must change or cancel your appointment we ask that you contact our office at least 24 hours prior to your scheduled appointment. To notify us of a need to change or cancel your appointment after business hours, please leave a message on our billing office voicemail at 847-775-1112.

Insurance and Payment Information

Allergy & Asthma Consultants accepts most major insurance plans and Medicare. Please direct specific questions regarding insurance coverage and benefits, including allergy testing, to your insurance company. Co-payments will be collected at the time of service, and patients are responsible for charges not covered by insurance. When necessary, our billing staff will work with patients to set up a payment plan. If you have questions regarding the insurance plans we accept or would like an estimate of charges for our services, please contact us at 847-775-1112.

We look forward to seeing you at your appointment!

Mark E. Kaplan, M.D.

36100 N. Brookside Drive, Suite 203
Gurnee, IL 60031
847-855-1570

Stacie A. McMurtry, M.D.

1800 Hollister Drive, Suite 106
Libertyville, IL 60048
847-549-7711

Sandra Denman, PA-C

www.allergy-asthmaconsultants.com



PATIENT REGISTRATION FORM

(Online Copy)

MARK E. KAPLAN, MD
STACIE A. McMURTRY, MD
SANDRA N. DENMAN, PA-C

36100 North Brookside Drive, Suite 203, Gurnee, IL 60031
(847) 855-1570 • Fax (847) 855-1890

1800 Hollister Drive, Suite 106, Libertyville, IL 60048
(847) 549-7711 • Fax (847) 549-1020

(PLEASE PRINT CLEARLY)

Today's Date: (Month/Day/Year)

E-mail:

*Patient Name: (Last) (First) (Middle Initial)

*Address: (Street) (City) (State) (Zip)

*Date of Birth: (Month/Day/Year) Age: *Sex: M F Marital Status: S M W D

*Home #: () Work #: () ext () Cell #: () (Please indicate [] which phone number above we should use as your primary contact number)

*Referring Physician: (Name) (Address) (Phone)
~ Referring physician will receive a consultation letter for your initial visit. If none, please write none ~

Referred By: (Name) (Address) (Phone)

Are any members of your family patients of Allergy & Asthma Consultants? Yes No (Name)

Name of Spouse/Parent: (Name) (Address)

*Guarantor for Bill: (Name) (Address) (Social Security #)

Guarantor Employer: (Name) (Address) (Phone #)

*Primary Insurance Company: (Carrier Name) *Group & ID #: (Group) (ID #)

*Claims Mailing Address:

*Policy Holder Name: *Date of Birth: / /

*Secondary Insurance Company: (Carrier Name) *Group & ID #: (Group) (ID #)

*Claims Mailing Address:

*Policy Holder Name: *Date of Birth: / /

~ We will require a copy of all valid insurance cards to submit your claims ~

I hereby authorize my insurance benefits to be paid directly to the above-assigned physicians for todays and all future services. Realizing I am responsible to pay any non-covered services. I hereby authorize the release of pertinent medical information to my insurance carrier(s).

X Patient Signature / Guarantor Date

THANK YOU FOR CHOOSING ALLERGY & ASTHMA CONSULTANTS, LTD.

PLEASE COMPLETE THE OTHER SIDE OF THIS DOCUMENT.

ALLERGY SURVEY

Patient Name: _____

Today's Date: _____

Please complete this allergy information list by circling or underlining applicable conditions.

Current complaint/symptoms: _____

- EYES:** itching burning tearing swelling redness discharge
- EARS:** itching fullness popping frequent infections draining
Tubes? Yes No If Yes, Date: _____
- NOSE:** itching blocked sneezing running nosebleeds snoring mouth breathing decreased smell
frequents colds polyps (Date of last sinus CT scan: _____)
- THROAT:** sore mucous post-nasal discharge itching hoarseness
Tonsil & Adenoid Removal? Yes No If Yes, Date: _____
- CHEST:** cough wheeze pain tightness sputum (color _____ amount _____)
shortness of breath: at rest after exertion (Date of last chest x-ray: _____)
- SKIN:** rash eczema hives swelling itching dry
- G-I:** nausea cramping gas diarrhea vomiting weight loss difficulty swallowing heartburn
- HEAD:** headache dizziness lightheaded pressure vertigo
- GENERAL:** fatigue fever tension sweats chills insomnia
- PAST HISTORY:** asthma hay fever eczema hives insect allergy sinus infections pneumonia ear infections
bronchitis croup
Please list all known food, drug and animal allergies:

Previous allergy medications including OTC medications? Yes No

If Yes, Drug names & Dates of use: _____

Previous treatment by an allergist? Yes No

If Yes, Dates _____ Dr. _____ Address _____

Previous allergy injections? Yes No

If Yes, Dates _____ Dr. _____ Address _____

Past major illnesses & Dates: _____

Past major hospitalizations & Dates: _____

Current medications: Please list all current medications including OTC medications

When do symptoms occur?: spring summer fall winter morning night day indoors outdoors
exertion weather change emotions old-leaves hay lakeside barns summer home basement attic
lawn-mowing animals alcohol air conditioning heat dampness/humidity cold
perfumes chemicals paints hairspray tobacco ozone insecticides newsprint cosmetics latex

Do you smoke? Yes No

Are you exposed to smokers? Yes No

Do symptoms occur after eating? Yes No If Yes, please list all known or suspected foods:

FAMILY HISTORY: Any family members with allergies or asthma? Yes No If Yes, please indicate.

Father Mother Sister(s) Brother(s) Grandparent(s)

ENVIRONMENT: Occupation _____ List work exposures, if any _____

Recreation & hobby exposure list _____

Pets/Animals: Dog(s) Cat(s) Bird(s) Other(s) _____

Bedroom exposures: quilts comforters drapes blinds wall hangings books stuffed animals shutters
air conditioner humidifier air cleaner

Pillow: Synthetic Feather Carpet in Bedroom? Yes No

Bedroom heat type: Forced Air / Baseboard / Radiator Any stuffed bedroom furniture? Yes No

(SIDE 2)

FOR OFFICE USE ONLY: Reviewed by _____ Date _____

Allergy & Asthma Consultants, LTD

Version Date:
05/21/2014

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ALLERGY & ASTHMA CONSULTANTS, LTD.

1800 HOLLISTER DR, STE 106
LIBERTYVILLE, IL 60048

36100 N BROOKSIDE DR, STE 203
GURNEE, IL 60031

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received (if requested) the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Print Name & Signature _____

Date _____

Name(s) of other parties allowed access to your records: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason _____
