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	Clarinex/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.   **Stacie A. McMurtry, M.D.**   **Sandra Denman, PA-C**

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

1800 Hollister Drive, Suite 210
Libertyville, IL 60048
847-549-7711

www.allergy-asthmaconsultants.com

Rev. 12/01/2015

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 210, 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)

***Primary Care/ Referring Physician(s)**: ____
(Name) (Address) (Phone)

____
(Name) (Address) (Phone)

~Primary Care/ Referring physician(s) may receive a consultation letter(s) for your initial visit, upon your request. If none, please write 'None' ~

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**: ______________________________ ***Group & ID #**: __________/__________________
*(Carrier Name) *(Group) *(ID #)

***Claims Mailing Address**: ____

***Policy Holder Name:** ____ ***Date of Birth:** _____/_____/__________

***Secondary Insurance Company**: ______________________________ ***Group & ID #**: __________/__________________
*(Carrier Name) *(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) and listed Primary and/or Referring physicians.

X______________________________ ______________
Patient Signature / Guarantor **Date**

THANK YOU FOR CHOOSING ALLERGY & ASTHMA CONSULTANTS, LTD.

PLEASE COMPLETE THE OTHER SIDE OF THIS DOCUMENT.

Version Date: 08/23/2016

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:
____

SMOKING HISTORY Current ? ❑ Yes ❑ No If 'Yes' _______ packs/day for ______ years
Former? ❑ Yes ❑ No If 'Yes' _______ packs/day for ______ years Date quit _______
Are you exposed to smokers? ❑ Yes ❑ No

Current medications: Please list **all** current medications including OTC medications (Use separate sheet if necessary)
____

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: ____

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 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

FOR OFFICE USE ONLY: Reviewed by _____________ Date ___________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ALLERGY & ASTHMA CONSULTANTS, LTD.

1800 HOLLISTER DR, STE 210
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**__________________________________

____