ADVANCED ALLERGY & ASTHMA ASSOCIATES, P.C. • Steven J. Simonte, M.D.
305 Broadway-Suite 525 New York, NY 10007

PATIENT INFORMATION FORMS

1) PATIENT NAME:
FIRST Middle LAST Suffix

2) DATE OF BIRTH: Sex: ☐MALE ☐FEMALE Social Security #:
Month Day Year

3) PATIENT HOME ADDRESS:
STREET APARTMENT NUMBER CITY State ZIP CODE

4) HOME TELEPHONE: EMAIL:
CELL Phone Number: Work Number:

5) Emergency Contact: Telephone Number Emergency Contact:

6) PRIMARY CARE PHYSICIAN: Physician Phone Number:

7) CONSULT REQUESTED BY:

INSURANCE INFORMATION:
Insurance *SUBSCRIBER* ⇨ ONLY if different from patient (for insurance purposes only):

8) CARDHOLDER:
FIRST Middle LAST Suffix

9) DATE OF BIRTH: Sex: ☐MALE ☐FEMALE Social Security #:
MONTH DAY YEAR

10) HOME ADDRESS (only if different from patient):
Street / Apt. City State ZIP CODE

11) HOME TELEPHONE:
Cell Phone Number: Work Number:

12) SUBSCRIBER IS THE: *Father Mother Son Daughter Wife Husband Self Other* OF THE PATIENT
(PLEASE CIRCLE ONE OF THE ABOVE)

Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. If you do not obtain a valid referral, and your insurance company requires one, then services are considered not-covered and you are responsible for payment. It is your responsibility to pay any co-payment and deductible amounts required by your insurance carrier. In order to control the cost of billing, we request that charges for office visits be paid at the conclusion of each visit.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans to the practice named on this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize your office to leave reminder messages on my voice mail/answering machine.

____________________________ _______________
SIGNED (patients over 18/ parent or guardian) DATE

____
NAME (please print)

ADVANCED ALLERGY & ASTHMA ASSOCATES, P.C. FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help by eliminating the need for us to bill you. The following is a summary of our financial policy:

Patients are responsible for all office charges not covered by their insurance such as co-insurance, deductibles and co-payments. **Co-payments are due at the time of service according to the terms of your insurance company.**

Patients receiving allergy injections are expected to make their co-payment at the time the injection is given. This significantly reduces billing cost.

If your insurance plan requires, you must contact your Primary Care Physician to obtain a **referral** prior to your visit. Obtaining these referrals is your responsibility and we cannot provide service to you without them.

As a courtesy we will bill you for co-insurances and deductibles after we have heard back from your insurance. We urge our patients to call their member services to see if their policy has deductibles, co-insurance or co-payments for our services. Your plan may have these additional costs to keep premiums down. If you have another visit and there is a prior balance due, you will be asked to pay it at that time.

Payments may be made by cash, check, money order or credit card. We accept MasterCard, Visa & American Express. Patients with an outstanding balance of 60 days will be asked to speak with our Billing Department prior to scheduling an appointment.

Unpaid balances are billed monthly. We use computer billing and are aware that sometimes errors do occur. Please call if you have a question about your bill. Most problems can be settled paying and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill or are unable to pay on the day you are to be seen, please explain the situation to us. Satisfactory arrangements can almost always be made. We strive to remain flexible and understanding of individual circumstances, and will do our best to help. Financial considerations should never prevent you from receiving the care you need at the time you need it.

Effectively immediately our office has instituted a **$100 fee for missed appointments**. This has been made necessary by increasing number of people not keeping their appointment time. A cancelled or rescheduled appointment allows us to bring in a patient who may be on a waiting list trying to urgently see the doctor. We appreciate your understanding in helping us provide you with the best care we can.

I the undersigned understand this financial responsibility as stated above.

Signature: ______________________________ Date: ____________________

Print name: ______________________________ Patient Name (if minor): ________________

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305 Broadway-Suite 525
New York, NY 10007

Steven J. Simonte, M.D.
Diplomate American Board of Allergy & Immunology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPPA Compliance Officer: Steven J. Simonte, M.D.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that the 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

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization's Privacy officer 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 healthcare operations and I also understand that you are not required to agree to my requested restrictions, but if you do agree, than you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (**PLEASE PRINT**) ______________________________

Signature ______________________________ Date ______________

Relationship to Patient ______________________________

For office use only:

Signed form received by: ______________________________

☐ Acknowledgement refused:

☐ Efforts to obtain: ______________________________
____

Reason for refusal: ______________________________
____

ADVANCED ALLERGY & ASTHMA ASSOCIATES, P.C.

Adult & Pediatric Allergy & Asthma

STEVEN J. SIMONTE, M.D.
Diplomate, American Board of Allergy & Immunology
TEL 212.924.7908

305 Broadway-Suite 525
New York, NY 10007

PATIENT ALLERGY HISTORY FORM

PATIENT NAME: ____________________ Age: ______ Date: __________

CONSULT REQUESTED BY: ____________________ **Primary Care Physician:** __________

WHAT IS THE MAJOR REASON(S) FOR THIS ALLERGY/ASTHMA CONSULTATION?

PLEASE DESCRIBE: ____

____

☆COMPLETE THE FOLLOWING SECTION IF THERE IS A HISTORY OF NASAL, SINUS, EYE or EAR SYMPTOMS☆

CIRCLE any of the following if they apply to you: *NONE*

Nasal stuffiness/congestion *Sneezing* *Post Nasal Drip* *Itchy Nose* *Itchy Eyes* *Watery Eyes*

Ear problems *Headache* *Sinus Pressure* *Circles under the eyes* *Other:* __________

Nasal Discharge/Runny Nose: *NONE* *Clear* *White* *Yellow* *Green*

WHEN are you **SYMPTOMATIC**? *SPRING* *SUMMER* *FALL* *WINTER* *YEAR-ROUND*

WHEN are your symptoms the **WORST**? *SPRING* *SUMMER* *FALL* *WINTER* *YEAR-ROUND*

HOW LONG have you had your symptoms? ______________________________

WHAT ALLERGY MEDICATIONS (antihistamines/nasal sprays/eye drops/decongestants) **HAVE YOU TAKEN & HOW EFFECTIVE WERE THEY?**

__________ ______________ __________ ______________

__________ ______________ __________ ______________

__________ ______________ __________ ______________

SUSPECTED or KNOWN CAUSES of these symptoms *(please circle all that apply):*

Dust *Trees* *Grass* *Weeds* *Mold* *Dogs / Cats* *Latex* *Cigarette Smoke*

Foods *Odors/Fumes* *Perfume* *Mowing Lawn* *Cold Weather* *Spicy foods* *Alcohol* Other: ______

Number of SINUS Infections treated in the Past Year: _____ *NONE*

Number of EAR Infections treated in the Past Year: _____ *NONE*

Last **Antibiotic** used for Sinus or Ear Infections (**NAME of DRUG & DATE of USE**): ____________________

Have you had a **Sinus X-RAY**? *YES* *NO* Date(s): ______________

Have you had a **Sinus CAT SCAN**? *YES* *NO* Date(s): ______________

Have you had **SINUS SURGERY**? *YES* *NO* Date(s): ______________

History of **NASAL POLYPS**? *YES* *NO* Date(s): ______________

History of **EAR TUBES**? *YES* *NO* Date(s): ______________

Do you wear **CONTACT LENSES**? *YES* *NO*

History of **Enlarged Tonsils/Adenoids**? *YES* *NO*

Have you had **Tonsils/Adenoids Surgically Removed**? *YES* *NO* Date: __________

PATIENT NAME: ______________________ Advanced Allergy & Asthma Associates, P.C.

☆ COMPLETE THE FOLLOWING SECTION IF THERE IS A HISTORY OF ASTHMA, WHEEZING, OR COUGH ☆

❑ **NOT APPLICABLE (NO history of breathing or respiratory symptoms)**

❑ **DATE Breathing Symptoms First Started:** ______________________

DESCRIPTION of SYMPTOMS *(please circle all that apply):* *DRY COUGH* *WET COUGH* *WHEEZING* *SHORTNESS OF BREATH*

CHEST TIGHTNESS *TIGHTNESS IN THROAT* *SPUTUM/ PHLEGM (please circle sputum color: CLEAR WHITE YELLOW GREEN)*

WORSE AT NIGHT *WORSE DURING THE DAY* *PROBLEM DURING THE DAY & NIGHT*

Frequency of DAY time SYMPTOMS: *LESS THAN 2 DAYS A WEEK* *3 OR MORE DAYS A WEEK* *EVERY DAY* *CONTINUAL*

Frequency of NIGHT time SYMPTOMS: *LESS THAN 2 NIGHTS/MONTH* *>2 NIGHTS/MONTH* *>1 NIGHT/WEEK* *FREQUENT*

When are you SYMPTOMATIC? *SPRING* *SUMMER* *FALL* *WINTER* *YEAR-ROUND*

Any EMERGENCY Room Visits for Asthma/Breathing Problems: *NONE* *1 - 2* *3 - 5* *>5* Date(s): ____________

HOSPITALIZATIONS for Asthma/Breathing Problems: *NONE* *1 - 2* *3 - 5* *>5* Date(s): ____________

If hospitalized for asthma, were you ever admitted to an **Intensive Care Unit** (ICU): *NO* *YES* Date(s): ____________

How many times in the **past year** have you been on **ORAL STEROIDS** (Prednisone, Orapred, etc.) **for Asthma?** ______. *NONE*

Please list the **ASTHMA MEDICATIONS** that you are taking/have taken: *NONE*

____________ ____________ ____________

____________ ____________ ____________

SUSPECTED or known TRIGGERS of ASTHMA/Respiratory Symptoms *(please circle all that apply):*

Dust *Trees* *Grass* *Weeds* *Mold* *Dogs / Cats / Animals* *Exercise* *Cigarette Smoke*

Colds/Infections *Odors/Fumes* *Perfume* *Weather Changes* *Emotions/Stress* *Mowing Lawn* *Reflux/Heartburn*

Foods *Cold Air* *Humidity* *Pollution* Other: ____________

Previous History of **PNEUMONIA?** *YES* *NO* Number of Episodes:______ Date(s):____________

Previous History of **BRONCHITIS?** *YES* *NO* Number of Episodes:______ Date(s):____________

Last **ANTIBIOTIC** used for Pneumonia or Bronchitis (name of drug & date of use):____________

Have you had a CHEST X-RAY? *YES* *NO* **Date(s) of Chest X-Ray:** ____________

Have you had a CHEST CT/CAT SCAN? *YES* *NO* **Date(s) of Chest CT/CAT Scan:** ____________

☆ COMPLETE THE FOLLOWING SECTION IF THERE IS A HISTORY OF SKIN PROBLEMS/RASH/ECZEMA ☆

NONE *ECZEMA* *HIVES* *SWELLING* *CONTACT RASH* Other: ____________

Approximate DATE when symptoms first started: ____________ Known or suspected CAUSES of rash: ____________

DID ANY OF THE FOLLOWING OCCUR AROUND THE TIME OF ONSET OF THE RASH *(please circle all that apply)?*

Foreign travel *Change in Medications* *Infection/Cold/Flu* *Change in Cosmetics* *Exposure to Animals* *Exposure to Latex*

Change in Detergents *Diarrheal Illness* *Course of Antibiotics* *Change in Soap, Shampoo, etc.* *Change in Diet*

Change in Home/ Work Environment *Insect Sting/Tick Bite* *New Clothing/Jewelry* Other:____________

PLEASE list any **MOISTURIZERS** or **SKIN MEDICATIONS** that you are currently using: ____________

____________ ____________ ____________ ____________

PATIENT NAME: ______________________________ **Advanced Allergy & Asthma Associates, P.C.**

☆ HAVE YOU HAD ANY **REACTIONS TO BEE/INSECT STINGS**? *(please circle):* *NONE* *NEVER STUNG*

LOCAL REACTION/SWELLING AT STING SITE *HIVES / RASH* *DIZZINESS / THROAT TIGHTNESS / BREATHING PROBLEMS* *ANAPHYLAXIS*

☆ HAVE YOU HAD ANY **PREVIOUS ALLERGY TESTING?** *NO* *YES*

If **YES**: Date: ________________ Testing was **POSITIVE** to: ______________________________

Have you ever been on **ALLERGY INJECTIONS** *(please circle):* *NO* *YES* Name of previous Allergist: __________

Previous Injection Dates: ______________________ Date of Last Injection: ____________________

☆ HAVE YOU HAD ANY **ALLERGIC REACTIONS to FOODS?** *NO* *YES*

If **YES**, please list **DATE OF REACTION, FOOD INVOLVED & SYMPTOMS EXPERIENCED:**

______________ ______________ ______________________

______________ ______________ ______________________

☆ **PAST MEDICAL HISTORY:** **List all Medical Conditions:** *NONE*

______________ ______________ ______________

______________ ______________ ______________

List any Emergency Room visits, Hospitalizations, & Surgeries: *NONE*

______________ ______________ ______________

______________ ______________ ______________

For WOMEN only: Are you pregnant? *NO* *YES* Are you planning to become pregnant in the next year? *NO* *YES*

Please **CIRCLE** any additional problems that you are experiencing:

Depression / Anxiety *Fatigue* *Visual Changes* *Hearing Problems* *Throat Problems* *Breathing Problems / Emphysema / COPD*
Chest Pain / Palpitations *High Blood Pressure* *High Cholesterol* *Diabetes* *Rash / Itching* *Thyroid Problems* *Seizures* *Colitis*
Bladder Problems *Muscles Aches* *Joint Pains* *Heartburn/Reflux* *Bleeding / Clotting Problems* *Hormone Problems* *Weight Change*

☆ LIST ANY **MEDICATIONS** taken in the past week (include Aspirin/Vitamins/Over-The-Counter medications): *NONE*

__________ __________ __________ __________ __________

__________ __________ __________ __________ __________

☆ HAVE YOU EVER HAD ANY **ALLERGIC REACTIONS to MEDICATIONS and/or IV CONTRAST?** *NO* *YES*

If **YES**, please list **DATE OF REACTION, DRUG INVOLVED, & SYMPTOMS EXPERIENCED:**

__________ ______________ ______________________

__________ ______________ ______________________

☆ **IMMUNIZATION HISTORY:** Are you (or your child's) immunizations up to date? *NO* *YES*

Have you (or your child) ever had a chicken pox infection (varicella) or received the vaccine for chicken pox? *NO* *YES*

Have you (or your child) ever had a reaction after receiving an immunization? *NO* *YES* If **YES**, please describe the reaction below:

____

PATIENT NAME: ______________________________ **Advanced Allergy & Asthma Associates, P.C.**

☆ **SOCIAL HISTORY:** **MARITAL STATUS** (patient or parents if minor): *Single* *Married / Domestic Partner* *Divorced* *Widowed*

Children, or siblings if minor: ____

SMOKING history: *NEVER* *CURRENT* *PAST* **Packs Per Day:** ________ **For How Long:** ________ **When Did You Quit:** ________

Drug/Alcohol Use: ____

☆ **FAMILY MEDICAL HISTORY:** Enter age & **circle below** if family members have a significant history for any of the following:

MOTHER	Age: _____	*ASTHMA*	*ECZEMA*	*FOOD ALLERGY*	*HAY FEVER/ ENVIRONMENTAL ALLERGIES*	Other: ________
FATHER	Age: _____	*ASTHMA*	*ECZEMA*	*FOOD ALLERGY*	*HAY FEVER/ ENVIRONMENTAL ALLERGIES*	Other: ________
BROTHERS	Age(s): ________	*ASTHMA*	*ECZEMA*	*FOOD ALLERGY*	*HAY FEVER/ ENVIRONMENTAL ALLERGIES*	Other: ________
SISTERS	Age(s): ________	*ASTHMA*	*ECZEMA*	*FOOD ALLERGY*	*HAY FEVER/ ENVIRONMENTAL ALLERGIES*	Other: ________
SONS	Age(s): ________	*ASTHMA*	*ECZEMA*	*FOOD ALLERGY*	*HAY FEVER/ ENVIRONMENTAL ALLERGIES*	Other: ________
DAUGHTERS	Age(s): ________	*ASTHMA*	*ECZEMA*	*FOOD ALLERGY*	*HAY FEVER/ ENVIRONMENTAL ALLERGIES*	Other: ________

☆ **ENVIRONMENTAL HISTORY:**

List **ALL SMOKERS** who live in the home ____

List **ALL ANIMALS** in or around the home ____

How long have animals been in or around the home? ____________ Pets allowed in the bedroom? *YES* *NO*

Any problems with **PEST INFESTATION**? *NONE* *Cockroach* *Mouse* *Rat* Other: ____________

DWELLING TYPE: *Apartment* *Loft* *Townhouse* *House* *Basement Apartment*

Age of Building: ____________ **How long have you lived there?** ____________

Heating System: *Radiator* *Forced Hot Air* *Baseboard* *Wood Burning Stove* Other: ____________

Air Conditioning: *NONE* *Window* *Central*

Floor Covering: *Wood Floor* *Area Rug* *Wall to Wall Carpet* *Carpet over Cement* Other: ____________

Air Filter/Cleaner: *NONE* *Room* *Central* **Are you using a HEPA Air Filter or HEPA Air Cleaner?** *YES* *NO*

Basement: *NONE* *Unfinished* *Finished* *History of Water Leakage* *Damp* *Dry* *Musty / Visible Mold*

Bedroom: Winter bedroom temperature: _______ **Are you using Allergy Covers/Dust Mite Encasings?** *YES* *NO*

Type of Pillow: *Synthetic* *Feather*

Bedding: *Feather Bed* *Feather Comforter*

Description of Bedroom: *Neat* *Cluttered* *Dusty* *Stuffed Toys*
Curtains *Drapes* *Blinds* *Window Shades* *Upholstered Furniture*

☆ **OCCUPATIONAL EXPOSURES:**

Please describe **TYPE OF WORK OR DAILY ACTIVITITY:** ____________________________

Please circle: *Office Setting* *Outdoor Setting* *Homemaker* *Pre-School* *School (Grade_____/College Student)*

Are symptoms affected by work or school? ____

Please inform the physician of any additional history or problems you are experiencing.
Thank you for your time in filling out these forms.