Pediatric and Adult Asthma, Allergy & Immunology

New Patient Forms

PLEASE READ

Completing these forms in advance of your visit can save you significant time in the waiting room and during your visit.

It is important that you use **BLACK INK.**

If your insurance requires that you obtain a referral from your primary physician prior to seeing a specialist, it is mandatory that we have the referral at the time of your visit. Otherwise, your visit will need to be rescheduled.

Lisa Barisciano, MD
Pediatric and Adult Asthma, Allergy & Immunology, LLC
15 James Street
Florham Park, NJ 07932
P 973 503 0600
F 973 503 0424
www.hanoverallergy.com

Lisa Barisciano, M.D.
Pediatric and Adult Asthma, Allergy & Immunology

15 James Street
Florham Park, NJ 07932
(973) 503-0600 Fax (973) 503-0424
www.hanoverallergy.com

NEW PATIENT QUESTIONNAIRE

Please answer all the questions that apply to you or your child (hereafter referred to as "you") and bring this form with you on the day of your visit.

PATIENT'S NAME:	**DATE OF BIRTH:**
REFERRED TO THIS OFFICE BY:	**PRIMARY CARE PHYSICIAN:** **ADDRESS:** **PHONE:**

1. **CHIEF COMPLAINT** *(Reason for Visit)*: _____
   _____
   _____

2. **HISTORY OF PRESENT ILLNESS (PHYSICIAN TO COMPLETE)**: _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

3. **REVIEW OF SYSTEMS (PROBLEMS):** *Have you had any of the following symptoms or conditions? Check all that apply.*

System	***No***	***Yes***	***Check all that apply***	***Age of onset***	***All-year or seasonal?***	***Indoor or outdoor?***	***Comments***
Eyes			[ ] red, [ ] watery, [ ] itchy, [ ] swollen, [ ] mucus discharge [ ] light hurts eyes				
Ears			[ ] itchy, [ ] frequent infections (#__/yr)				
Nose			[ ] stuffy, [ ] itchy, [ ] sneezing, [ ] runny, _____ color, [ ] snoring, [ ] mouth breathing				
Sinus			[ ] frequent sinus infections (#___) [ ] thick discharge, yellow/green [ ] headaches				
Throat			[ ] post nasal drip, [ ] sore, [ ] itchiness, [ ] throat clearing, [ ] difficulty swallowing				
Chest			[ ] cough, [ ] wheezing, [ ] shortness of breath, [ ] bronchitis, [ ] pneumonias				

System	*No*	*Yes*	*Check all that apply*	*Age of onset*	*All-year or seasonal?*	*Indoor or outdoor?*	*Comments*
Abd/GI			[ ] frequent diarrhea, [ ]vomiting [ ] reflux, [ ] food allergies				
Skin			[ ] eczema, [ ] hives, [ ] dry skin, [ ] dry patches, [ ] frequent infections				
General			[ ] weight loss [ ] failure to gain weight				
Other			[ ] other infections requiring antibiotic therapy				

4. DIETARY HISTORY/FOOD REACTIONS:

- *If patient is a child, is or was the patient exclusively breastfed?* _____
  for how long? _____
- *When was formula introduced?* _____
  Which formula? _____
  Reactions? _____
- *Do you have any special diet?* _____
- *Are you avoiding any foods?* _____

FOOD	AGE	SYMPTOMS/REACTIONS	STILL AVOIDING?

5. **PRECIPITATING FACTORS/TRIGGERS:** *Please check boxes*

	Yes	No		Yes	No
Tree exposure			Tobacco smoke		
Grass Exposure			Exercise		
Raking leaves/mowing lawns			Animals (cats, dogs, etc.)		
Damp areas with mold and mildew			Cold or hot water		
Sweeping, dusting, vacuuming			Colds (upper respiratory infections)		
Smog/air pollution			Cleaning agents, fumes, perfumes		
Aspirin/Ibuprofen/other drugs			Menstrual periods		
Nighttime			Insect stings		
Temperature changes (hot/cold)			Others:		
Itchy lips/throat after eating bananas, melons, peaches, apples, kiwi, pears, citrus, shellfish, peanuts, or tree nuts					

6. PREVIOUS ALLERGY EVALUATION AND TREATMENT:

- *Have you ever had allergy skin testing?* ☐*Yes* ☐*No* *Date:* _____ *Physician:* _____
  Results: _____

- *Have you ever had **RAST** testing (blood test)?* ☐*Yes* ☐*No* *Date:* _____ *Physician:* _____
  Results: _____

- *Have you ever received immunotherapy (allergy shots)?* ☐*Yes* ☐*No*
  Date: _____ *Physician:* _____

- *Have you ever used:*
  [ ] Nasal Sprays: [ ]Rhinacort [ ]Flonase [ ]Nasonex
  [ ] Inhalers: [ ]Proventil/albuterol [ ]Flovent [ ]Pulmicort [ ]Advair [ ]Maxair [ ]Intal
  [ ] Medications: [ ]Singular [ ]Claritin [ ]Allegra [ ]Benedryl [ ]Atarax [ ]Prednisone [ ] Prelone

7. PAST MEDICAL/SURGICAL HISTORY: *Have you ever had any of the following conditions?*

List other medical illnesses:	**ER/Hospitalizations?** When/why	**Any surgeries?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	
_____		
		[ ] Tonsils/adenoids removed, if yes, when? _____
[ ] Cough up blood	**Abnormal tests?**	[ ] Sinus surgery?
[ ] Tuberculosis	[ ] Chest XR, when _____	[ ] Myringotomy (tubes in ears)?
[ ] Glaucoma	[ ] CT scan	
[ ] Kidney problems		
[ ] Snoring/mouth breathing		
[ ] Diabetes		

8. **MEDICATIONS**: *Do you take any medications currently? Please list all medications and dosages.*

_____
_____
_____
_____

9. **ALLERGIES:** *Do you have any known allergies to medications, foods, or drugs? If so, what was your reaction?* _____
_____
_____

10. FAMILY HISTORY:

Mother's health _____age_____Father's health _____age_____
Brother(s) health _____age_____Sister(s) health _____age_____

Do any family members have a history of allergic or immunologic conditions? If yes, please complete all that applies.

ALLERGY/DISEASE	YES	NO	LIST RELATIVES (INDICATE IF OUTGROWN AND WHEN)
Asthma			
Frequent bronchitis			
Frequent pneumonias			
Cystic fibrosis or other lung disease			
Hay fever / allergic rhinitis			
Chronic sinus problems			
Hives / urticaria			
Eczema			
Insect allergy			
Drug allergy			
Food allergy			
Immune disorder			
Autoimmune disorder (lupus, thyroid disease, rheumatoid arthritis)			
Early unexplained death in infancy			
Other			

11. **ENVIRONMENT/HOME SURVEY**: *List city and states where you have lived, with most recent first.*

	City	State	Years	Effects on symptoms, better/worse/no change
1.				
2.				
3.				
4.				

- Approximately how old is your home? _____
- How long have you lived there? _____
- Is your home a **[ ]**single family home, **[ ]**brownstone/townhouse, **[ ]**apartment?
- Does it have **[ ]**central air conditioning, **[ ]**central or forced hot air, **[ ]**radiator heat, **[ ]**baseboard, **[ ]**window air conditioning, **[ ]**humidifier, **[ ]**damp areas, **[ ]**basement, **[ ]**visible mold, **[ ]**cockroaches, **[ ]**smokers?
- Does your bedroom have **[ ]**wall-to-wall carpeting, **[ ]**hardwood flooring, **[ ]** area rugs, **[ ]**down pillows and/or comforter, **[ ]**stuffed toys?
- Does your bedroom have **[ ]**dust mite proof pillow and/or mattress covers, **[ ]**HEPA filter, **[ ]**weekly washing of bed linens?
- Please list all fur-bearing pets (cats, dogs, birds, gerbils, hamsters, etc.)
  _____
- Do the pets enter your bedroom? _____bed? _____
- Is there any location where your symptoms are worse? _____
- What is your occupation? _____ Are your symptoms worse at work? _____
- How many days form school or work have you missed because of your asthma or allergies? __
- Smoke exposure: □ **Yes** □ **No** Where? _____

12. **IMMUNIZATIONS**: *Please list vaccinations which you have received within the last 5 years.*
_____
_____
_____

Lisa Barisciano, M.D.
Pediatric and Adult Asthma, Allergy & Immunology, LLC

□ New □ Update Information Name of Primary Physician:	Referring Physician:

PATIENT NAME (Last, First, MI)			**DATE OF BIRTH**	TELEPHONE (HOME)
E-MAIL Address				TELEPHONE (Work)
ADDRESS (Street, Apt #)				TELEPHONE (Mobile or Other)
CITY	STATE	ZIP	MARITAL STATUS	AGE

SEX (circle) Male Female	SOCIAL SECURITY NUMBER	EMPLOYMENT STATUS (circle) Full-Time Retired Part-Time Not Employed	PATIENT STUDENT STATUS (circle) If 19 Years or Older: Full-Time Part-Time Not a Student

NOTE: DATE OF BIRTH REQUIRED IN ALL SECTIONS

EMERGENCY CONTACT NAME & PHONE (& RELATIONSHIP)

RESPONSIBLE PARTY IF PATIENT < 18 YEARS OF AGE

RESPONSIBLE PARTY NAME (Last, First, MI)		**SEX**	**DATE OF BIRTH**	PATIENT RELATIONSHIP TO RESPONSIBLE PARTY Self Spouse Child Other: _____
RESPONSIBLE PARTY ADDRESS (Street, Apt. #)			**SOCIAL SECURITY NUMBER**	TELEPHONE (Work)
CITY	STATE ZIP	TELEPHONE (Home)		TELEPHONE (Emergency)

PRIMARY INSURANCE

PRIMARY POLICY HOLDER NAME		**SEX**	**DATE OF BIRTH**	PATIENT RELATIONSHIP TO INSURED PARTY Self Spouse Child Other: _____
PRIMARY INSURANCE CARRIER	TELEPHONE	GROUP NUMBER		POLICY ID NUMBER

SECONDARY INSURANCE

SECONDARY INSURANCE POLICY HOLDER NAME		**SEX**	**DATE OF BIRTH**	PATIENT RELATIONSHIP TO INSURED PARTY Self Spouse Child Other: _____
SECONDARY INSURANCE CARRIER	TELEPHONE	GROUP NUMBER		POLICY ID NUMBER

Does your primary or secondary insurance require a referral to see a specialist (circle)? Primary YES / NO Secondary YES / NO

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. I authorize Lisa Barisciano, MD to render needed treatment to the above named patient.

2. I authorize Lisa Barisciano, MD to release medical or other information, required in the course of examination or treatment, to process patient's claims.

3. I authorize my insurance to be paid directly to the treating physician. I understand that I am responsible for charges not covered by my insurance.

4. I understand that I am responsible for all charges incurred through Lisa Barisciano, MD. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

PATIENT / LEGAL SIGNATURE DATE

Lisa Barisciano, M.D.
Pediatric and Adult Asthma, Allergy and Immunology, LLC
15 James Street – STE 4
Florham Park, NJ 07932

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy on request.

Signature: _____ Date: _____

Relationship to the patient (if signed by a personal representative to the patient): _____