PHILIP L. PASTERNAK, M.D.
F.A.A.P., F.A.C.A.A.I.
PEDIATRIC & ADULT ALLERGY AND IMMUNOLOGY

BOARD CERTIFIED ALLERGY & IMMUNOLOGY
PRACTICE LIMITED TO ALLERGY

Patient Information

Last Name: _____ MI: _____ Date Of Birth: _____

First Name: _____ **Cell Phone**: _____

Street Address: _____ Home Phone: _____

City/State: _____ Zip Code: _____

Marital Status: S___M____D____W___Gender (M/F) ____ Employer/School_____

Email: _____

Primary Care Provider: _____Phone Number _____

Referring Doctor (If Any): _____Phone Number _____

Insurance 1: _____ Policy# _____ Copay _____

Insurance 2: _____ Policy# _____ Copay _____

Insurance 3: _____ Policy# _____ Copay _____

Policy Owner (*If different from patient)*

Last Name: _____ First Name: _____

Date of Birth: _____ Phone Number: _____

Street Address: _____ City/State: _____

Zip Code: _____ Employer: _____

Relation to Patient: _____

_____ Patient Signature

_____ Signature of Legal Guardian

_____ Name of Legal Guardian

United Healthcare Community Members Only:

You must have an electronic referral submitted through their system to be seen. This referral lasts a maximum of 6 months and you will be responsible for obtaining this referral each time. The office will verify the referral was received at arrival.

Doctor you contacted to send the referral _____

Approximate date you contacted the doctor _____

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Patient Consent and HIPPA Awareness

Notice of Privacy Practices provides information about how we may use/disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Allergy and Asthma Care of NJ has the right to disclose my personal and medical information with the healthcare providers listed below.
- Allergy and Asthma Care of NJ has the right to disclose my personal and medical information with family members/friends listed below.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Allergy and Asthma Care of NJ has consent to treat me until notified otherwise.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:
Please state individual providers or state "All Providers" as well

_____

_____

_____ _____

Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

I **do not** consent for my personal are medical information to be discussed or released BUT I consent to treatment

_____ _____

Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

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Patient Insurance Policies/Responsibilities

Patient's Name: _____

Your Responsibility: Familiarize yourself with the terms of your insurance coverage. You will be responsible for co- payments, deductibles, out of pocket maximums, and other non-covered services that insurance does not pay. A co-payment is required at time of visit. Please be prepared to provide a copy of your health insurance card prior to services

Our Commitment: For most insurance plans, we will bill your insurance company on your behalf. You will be responsible for paying any amount of your bill that your insurance company does not pay. If you make an overpayment, we will refund the amount after we receive all payments from your insurance company.

If You Are a Member of an HMO or PPO

Your Responsibility: Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) may have special requirements, such as a referral from your primary doctor or pre-certification for certain procedures. You are responsible for ensuring that all the requirements of your health insurance plan are met. If the requirements of your plan are not met, you will be responsible for payment of the entire visit.

Our Commitment: If we accept insurance assignment, we will bill your insurance company on your behalf. We will request additional payments from you for any amounts of your bill that your insurance company does not pay. If you make an overpayment, we will refund the amount after settlement with your insurance company.

If You Are Covered by Medicare

Your Responsibility: Familiarize yourself with your Medicare benefits. Medicare may pay all or a portion of your office visit charges, but understand that non-covered fees are your responsibility. Be aware that Medicare specifically excludes payment for certain services. Prior to services, please provide a copy of your Medicare card. Medicare deductible and coinsurance amounts are your responsibility, unless you have a Medicare supplemental policy that covers your Medicare Part B deductible/coinsurance.

Our Commitment: We will bill Medicare and any secondary insurance you may have on your behalf.

If You Are Covered by Medicaid

Your Responsibility: Familiarize yourself with your Medicaid benefits, and understand that non-covered fees are your responsibility and are due at time of visit. Medicaid may pay for all of your charges except for personal convenience items. Depending on the type of coverage, but be aware that Medicaid has payment limitations on a number of services. Prior to services, please provide a copy of your Medicaid card.

Our Commitment: We will bill Medicaid and any secondary insurance you may have on your behalf.

_____ _____

Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

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Allergy History

Name: _____ DOB: _____ Date: _____

Your Occupation: _____ Prominent material used at work: _____

What are your present symptoms of allergy and/or asthma?

_____

_____

_____

Symptoms Occur (please circle): All Year Winter Spring Summer Fall Other

What makes your symptoms worse? _____

What makes your symptoms better? _____

What medications have you tried for these symptoms?

_____

In the past year:

How many times have you visited the emergency room? _____

How many times have you been on Prednisone or Prelone? _____

How many times have you used a rescue inhaler? _____

What medications, including non-prescription medications, do you take daily or frequently? (Please circle)

Aspirin Cortisone Nasal Spray Hormones Laxatives Sedatives Vitamins Birth Control

Other_____

Are you allergic to any medications or foods? Yes/No_____ If yes what food and medication? _____

_____

Medical History

(Please Circle Applicable)

Thyroid Disease Diabetes High Blood Pressure Tuberculosis Kidney Disease Glaucoma

Heart Disease Heartburn Depression Liver Disease Headaches Sinus Issues

Other _____

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Does anyone in your home smoke? Yes _____ No _____ Do you Smoke? Yes _____ No _____

Have you ever smoked? Yes _____ No _____ When did you stop? _____

Household Information

Heating Systems: Hot water baseboard _____ Forced hot air _____ Electric Baseboard _____Gas _____ Oil _____ Wood Burning Stove _____ Fireplace _____

Air Conditioning: Yes _____ No _____ Central _____ Window Unit ____ Fans _____

Humidifier: Yes _____ No ____ Room Unit _____

Dehumidifier: Yes _____ No ____ Room Unit _____

Animal Exposure: Dog _____ Cat _____ Bird _____ Other _____

Carpets in Bedroom: Yes _____ No _____ Wall to Wall _____ Area Rug _____

Carpets in Living Area: Yes _____ No _____ Wall to Wall _____ Area Rug _____

Upholstered Furniture: Bedroom _____ Living Area _____

Mattress Type: Regular _____ Water _____ Age of Mattress _____

Comforter: Feather _____ Non-Feather _____

Pillow: Feather _____ Non-Feather _____

Family History

Is there a family history of allergies? _____

Which family member/s

Mother	**Asthma**	**Hay fever**	**Eczema**	**Hives**	**Sinus**
Father	**Asthma**	**Hay fever**	**Eczema**	**Hives**	**Sinus**
Brother/Sister	**Asthma**	**Hay fever**	**Eczema**	**Hives**	**Sinus**
Children	**Asthma**	**Hay fever**	**Eczema**	**Hives**	**Sinus**

_____ _____

Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian