

**Thank you for scheduling your appointment with
Allergy Associates of New Hampshire.
PLEASE COMPLETE FORMS AND BRING TO APPOINTMENT.**

Your appointment is on _____ at _____ am/pm., with: _____.

In the: Portsmouth, Rochester, York, Dover office.

- ❖ Please arrive 10-15 minutes prior to this time for patient registration.
- ❖ Plan on being in our office for 1-1 ½ hours.
- ❖ **IF YOUR APPOINTMENT IS WITH ONE OF OUR PHYSICIANS, PLEASE DO NOT TAKE ANTIHISTAMINES 4 DAYS PRIOR TO THIS VISIT,** (a list of antihistamines is on the back).
- ❖ Have your insurance card(s) with you and please make sure any referrals (if required by your insurance) are in place.
- ❖ Just a friendly reminder, co-payments are expected at the time of your visit.
- ❖ Please note our policy on missed or cancelled appointments: There may be a fee of \$50.00 for any appointment not cancelled with 24 hours notice. For your convenience you may leave a message on our answering machine to cancel an appointment after hours.

If you have any questions, please visit us on the web at www.allergiesnh.com or call us in:

Portsmouth: 603-436-7897 - Rochester: 603-335-2142 - York: 207-351-3932 -Dover 603-516-4232

Directions to the Portsmouth office: 100 Griffin Road

***From the south of Portsmouth,** take Route 95 North to Exit 3. Take a right at the light at the end of the ramp. Turn right at the second light onto Griffin Road. We are the first building on the right.

***From the north of Portsmouth,** take Route 95 South to Exit 3B. Take a right at the light at the end of the ramp (heading towards Portsmouth). Go through three sets of lights, and then turn right at the fourth light onto Griffin Road. We are the first building on the right.

Directions to the Rochester office: 60 Rochester Hill Road (Route 108)

***From the north of Rochester,** take Route 16 South. Take exit 12 onto Route 125 towards Rochester; turn left at the end of the ramp. Follow 125N to 108S. Turn right onto 108S continue **past** Frisbie Memorial Hospital for 2/10th of a mile. The office is located at 60 Rochester Professional Park (there is a sign) on the left.

***From the south of Rochester,** take Route 16 North. Take exit 12 onto Route 125 towards Rochester; turn right at the stop sign at the end of the ramp. Follow 125N to 108S. Continue **past** Frisbie Memorial Hospital for 2/10th of a mile. The office is located at 60 Rochester Professional Park (there is a sign) on the left.

Directions to the Dover office: 10 Members Way, Suite 200.

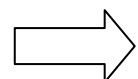
***From the north,** take Spaulding Turnpike to exit 9, Dover, take the Sixth St. ramp, and then take a right at the light on to Member's Way (Northeast Credit Union on corner). Take 1st left into parking lot. Enter building and take elevator to level two. We are suite 200.

***From the south,** take Spaulding Turnpike to exit 9. Take a left off exit and then take a right at traffic light (Northeast Credit Union on corner). Take a left into parking lot, enter building take elevator to level 2, Suite 200.

Directions to the York office: 127 Long Sands Road, Suite 6A.

***From north and south,** Take route 95 to exit 7. Travel south on Rt. 1 to the 1st set of lights, take left onto Rt. 1A (York St). Travel 1.5 miles to York Village Center, bear left at the statue on to Long Sands Rd. We are on the right in Long Sands Plaza, Suite 6A.

Please see reverse for additional information



- **Initial Visit:** The purpose of this visit is to obtain a detailed history of your problem and an adequate physical examination. Skin testing will also begin on this visit if necessary. Allow at least 1 and ½ hours for this appointment. **PLEASE DO NOT TAKE ANTIHISTAMINES 4 DAYS PRIOR TO THIS VISIT.**

The following is a partial list of antihistamines: Afrin Nasal Spray, Alavert, Allegra (*fexofenadine HCL*), Allegra D (*fexofenadine w/ pseudo*), Astelin Nasal Spray, Atarax (*hydroxyzine*), Benadryl (*diphenhydramine*), Bilastine, Bromfed, Clarinex (*desloratadine*), Claritin (*loratadine*), Claritin D (*loratadine w/ pseudo*), Chlor-trimeton, Dimetapp, Doxepin, Dry-lex, Extendryl Jr. Sr. *or* chewable, Neo-synephrine Nasal Spray, Nalamine, PBZ, PCM chewables, Palgic, Periactin, Rondec, Ryna 12, Rynatan, Tavist, Tavist D, Triaminic (*chlorpheniramine*), Zyrtec (*cetirizine HCL*), Xyzal, ANY OTC cough/cold combination medication or allergy medication ie: (Advil Allergy Sinus, Actifed, Drixoral, Pediacare cough/cold, Thera-Flu cough/cold, Robitussin cough/cold etc0)

SINGULAIR AND Plain SUDAFED are not antihistamines

- **Summary Conference:** When your initial evaluation is completed, a 1 hour summary conference is scheduled. This visit may consist of intradermal skin tests to complete the testing panel. Our findings and recommendations will be discussed and any questions answered during the course of your appointment. **PLEASE DO NOT TAKE ANTIHISTAMINES 4 DAYS PRIOR TO THIS VISIT.**
- **Appointments:** No one likes to wait in a physician's office. We seek your cooperation to be able to see every patient on time. Please arrive on time for each appointment. If you need to cancel an appointment, please call us as early as possible. We reserve the right to bill for appointments not cancelled within 24 hours prior to the visit. Also, if you have been seeing another physician for this problem, either have that office send your records to us or, preferably, bring them with you on your first visit.
- **Fee Schedule:** The following is an approximation of fees that **may** be charged.

Initial office visit/consultation	\$350.00		
Summary visit	\$180.00		
Prick tests, on first visit	\$ 10.50 ea.	food/environmental	\$28.00 ea. insect/medication
Intradermal tests, on second visit	\$ 12.50 ea.	food/environmental	\$28.00 ea. insect/medication

- **Financial Information:** The following information is provided to all patients to avoid any misunderstanding or disagreement concerning payment for professional services. If you have questions regarding your insurance coverage or need for referrals, please call your insurance company. If you have any questions regarding this financial information, please call our billing office at 603-436-7897 prior to your visit.

For your convenience we will bill your insurance company directly for professional services provided to you. Please note: We are not providers for Maine Medicaid. As a courtesy to you, we will also bill any secondary insurance coverage that you have. We cannot submit claims to insurance companies outside of the United States.

Depending on the insurance company, type of policy and the benefits provided, you may be responsible for a co-payment, a co-insurance and/or a deductible. **Co-payments and co-insurance are due at the time of your visit.** We accept cash, checks, M/C, Visa, and Discover. We will send you an itemized statement for amounts applied to your deductible or not covered by your insurance. All statements are due and payable upon receipt. Please note that your insurance coverage is an agreement between you and your insurance company and it is your responsibility to remit payment for charges not covered by your insurance company.

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain all referrals required by your insurance company. You will be responsible for payment on any claims denied by your insurance because no referral was obtained or the referral is invalid.

PATIENT INFORMATION

(Please print)

() Mr. () Mrs. () Ms. () Jr. () Sr. () Other _____ Marital Status () Married () Single () Divorced () Widowed () Legally Separated () Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Mailing Address _____ City _____ State _____ ZIP _____

Social Security Number _____ - _____ - _____ () Female () Male Date of Birth ____/____/____

Phone numbers Home _____ () Day () Evening Cellular _____ Work _____ () Day () Evening Pager _____

Primary Care Physician _____ Address _____ Phone _____

Employment Status () Employed () Full-Time Student () Part-Time Student () Retired () Self Employed () Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____ Relationship to patient _____

Name of Pharmacy _____ City/Town _____ Phone Number _____

RESPONSIBLE PARTY INFORMATION-if under age 18.

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Social Security Number _____ - _____ - _____ () Female () Male Date of Birth ____/____/____

Phone Numbers Home _____ Work _____ Relationship to patient _____

Street Address _____ City, _____ State _____ Zip _____

Employment Status () Employed () Full-Time Student () Part-Time Student () Retired () Self Employed () Unemployed

Employer _____ Employer phone number _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card(s) to the front desk at check in)

Insurance Company _____ Insurance Co. Phone Number (____) _____

Insurance Company Address _____

Name of Policy Holder _____ ID (policy number) _____ Group # _____

Policy Holder Date of Birth ____/____/____. () Male () Female Relationship to Patient _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Insurance Co. Phone Number (____) _____

Insurance Company Address _____

Name of Policy Holder _____ ID (policy number) _____ Group # _____

Policy Holder Date of Birth ____/____/____. () Male () Female Relationship to Patient _____

Do we have permission to leave messages on your answering machine or with others who may answer your phone? (please circle) YES or NO

I authorize Allergy Associates of New Hampshire to submit claims to my insurance carrier and to release any medical information necessary to process the claim. I also authorize payment of medical benefits to Allergy Associates of New Hampshire for any services for which they accept assignment. I understand that I am responsible for payment of co-payments, coinsurance, deductible amounts and claims denied for lack of a referral.

Signature _____ Date _____

Allergy Associates of New Hampshire Allergy Questionnaire

Carefully complete in full. Accuracy is essential. Please relate answers to your own experience, not to previous advice or skin tests.

Name _____ Date of birth _____

When did problem first start? (State problem in your own words) _____

What makes it better? _____

What makes it worse? _____

What do you think causes the problem? _____

Most severe during: (Circle) Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Do you have symptoms, even if mild, most days of the year? yes/no

During bad periods how often do symptoms occur? daily 2 x week weekly 2x month less

Days school/work missed last year because of problem _____

Do you ever wake up with symptoms? yes/no

Medications taken for the problem: (include number of times taken daily)

Asthma inhalers _____

Antihistamines _____

Nasal sprays _____

Eye drops _____

Steroids /Cortisone _____

Theophylline _____

Other _____

Have you ever seen an allergist? yes no Name _____ Address _____

Have you had x-rays? Sinus yes/no Chest yes/no. If yes, please obtain a copy of the report from your physician if possible along with any corresponding chart notes.

Have you ever received allergy injections? yes no

Circle any symptoms that bother you:

SKIN: rash, hives, eczema, blisters, swelling, burning, redness, itching, white spots, other _____

EYES: tearing, burning, itching, redness, discharge, puffiness, vision problems, pain

EARS: itch, deafness, pressure, infection, other _____

NOSE: stuffiness, runny, itch, sneeze, bleeding, swelling, post nasal drip, polyps, trouble smelling, other _____

SINUS: pain, swelling, infection, other _____

TONGUE: swelling, itch, sore, trouble swallowing, other _____

CHEST: shortness of breath, wheeze, cough, pain, tightness, trouble walking or sleeping, pneumonia, other _____

HEART: known heart condition, high blood pressure swelling of legs, other _____

STOMACH: pain, vomiting, diarrhea, constipation, blood in stool, gas, hiatal hernia, indigestion, other _____

Worse after eating what foods? _____

MUSCLES/JOINTS: pain swelling redness, stiffness, weakness, other _____

OTHER SYMPTOMS: recurrent fevers, night sweats, flu symptoms, thyroid disease, hair loss, other _____

CIRCLE THINGS WHICH AFFECT YOUR PROBLEM:

IRRITANTS: cleanser, detergent, cooking odor, perfume, powder, tobacco smoke, motor fumes, glue, insect spray, ammonia, chemical fumes, soap, after shave, hair dye, other _____

FOODS: milk, other dairy products, bread, nuts, chocolate, shellfish, fruits, spices, beer, wine, liquor, fish, other _____

ANIMALS: dog, cat, horses, birds, other _____

WEATHER: hot, cold, humid, damp, pollution, air conditioning, change in temperature, changes in weather, other _____

CONTACTS: grass, flowers, plants, hay, Christmas tree, raking leaves, dust, feathers, overstuffed furniture, rugs, stuffed toys, fur, rubber, plastic, other _____

INSECTS: type of reaction - hives, trouble breathing, other _____

EMOTIONS: financial, work related, marital problems, other _____

FAMILY HISTORY

List names and occupations of individuals residing in house.

	NAME	DATE OF BIRTH	OCCUPATION
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Please check (✓) any member of patient's family with the following problem(s).

PATIENTS	ASTHMA	HAY FEVER	ECZEMA	HIVES	OTHER LUNG PROBLEMS	OTHER ALLERGIES
GRANDMOTHER						
GRANDFATHER						
FATHER						
MOTHER						
BROTHER						
SISTER						
CHILDREN						

Does patient spend a lot of time with another family member yes/no If yes, who? _____

Patient's present occupation _____

Past occupation(s) with dates, involving Dust, Chemicals, Irritants, Powders, Fumes, etc. _____

Hobbies of family members involving Fumes, Odors, Dust, Chemicals _____

Past hospitalizations for this problem or other reasons _____

Other medical problems _____

Medications taken frequently including Aspirin, Birth Control Pills, Vitamins, Laxatives _____

CIRCLE ALL OBJECTS WHICH APPLY OR ARE PRESENT IN YOUR ENVIRONMENT

		COMMENTS	
HEATING SYSTEM:	Hot air Hot water		
	Electric Wood stove		
PETS:	Dog		
	Cat		
	Other		
PATIENT'S ROOM:	Bed:	Box Mattress Bunk beds	
		Foam mattress Other	
	Pillow:	Feather	
		Foam	
		Synthetic	
	Carpet:	Wall-to-wall	
		Area	
		No Rugs	
	Other:	Bureau - Cluttered/Clear	
		Night stand	
		Bookcase(s)	
		Wall hangings/Framed pictures	
		Stuffed furniture	
		Toy box With/Without lid	
		Desk - Cluttered/Clear	
		Other Furniture	
		Stuffed Toys	
		Shelves - Cluttered/Clear	
		Record Player	
		Perfume/Powder	
Drapes/Curtains			
Plants			

REMAINDER OF HOUSE:		COMMENTS
SMOKING:	Patient	
	Other Family Members	
CARPET:	Wall-to-wall	
	Area Rugs	
	No Rugs	
HUMIDIFIER: (Other than bedroom)	Room	
	Central	
HUMIDIFIER CLEANED:	Weekly	
	Monthly	
	Less	
Cellar:	Damp/Dry	
	Moldy	