AANH
Allergy Associates of New Hampshire

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Thank you for choosing Allergy Associates of New Hampshire for your health care needs.
Your first visit will require approximately 1 ½ hours of your time.
Patients under 18 must be accompanied by a parent or legal guardian.

_____ has an appointment on _____

at _____am/pm, with Dr. _____ in the Portsmouth Dover office.

Please arrive 30 minutes prior to your appointment time for patient registration.

New Patient Checklist

- **Please do not take antihistamines 4 days prior to this visit.** (a list of antihistamines can be found on the back of this page)
- Completed Patient Registration form (enclosed)
- Completed Allergy Questionnaire and Medication List (enclosed)
- Completed Notices and Disclosures form (enclosed)
- Photo ID
- Insurance card(s)
- Insurance copay if applicable
- Insurance referral if applicable (required for all HMO policies)
- Please have your referring physician fax any notes, reports (relevant labs, x-rays, CT or MRI scans) relating to the reason for your visit.
- Directions to our offices (on the back side of this page)

If you are unable to keep your appointment, please call our office at least 24 hours in advance.

We look forward to seeing you.

- **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. **Please do not take antihistamines 4 days prior to this visit.**

- **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, recommendations and any questions you may have will be discussed during this appointment. **Please do not take antihistamines 4 days prior to this visit.**

The following is a partial list of antihistamines: Actifed (*tripolidine*), Alavert, Allegra (*fexofenadine*), Antivert or Bonine (m*eclizine*), Atarax (*hydroxyzine)*, Benadryl (*diphenhydramine)* Bromfed, Clarinex (*desloratadine)*, Claritin (*loratadine)*, Claritin D (*loratadine w/ pseudo)*, Bromfed (b*rompheneramine*) Chlortrimeton (*chlorpheniramine*), Claritin (*loratidine*), Clarinex (*desloratadine*), Dimetapp, Doxepen, Dramamine (*dimenhydrinate*) Periactin (*cyproheptadine*) Phenergan (*promethazine*) Tavist (*clemastine*), Unisom (*doxylamine*), Zyrtec (*cetirizine*), Xyzal, OTC cough/cold medication or allergy Medication. Nasal Sprays: Astelin (*azelastine*), Astepro, Patanase. ***if you are unsure if your medication contains antihistamine, please call your pharmacist for verification**

Please contact us if you have any questions regarding your upcoming appointment.

Directions

Portsmouth office: 100 Griffin Road, Suite A

From the south, Take Route 95 North to Exit 3 • Take a right at the end of the exit ramp • At your second light, take a right on to Griffin Rd. • We are the first building on the right.

From the north, Take Route 95 South to Exit 3B • Take a right at the light on to Route 33 • Continue through three sets of lights. At your fourth light, take a right on to Griffin Rd. • We are the first building on the right.

Dover office: 51 Webb Place, Suite 230

Take Exit 9 off of the Spaulding Turnpike (Rt. 16) • Bear right off the exit, then turn right on to Central Avenue (Rt. 108 East) • Take a right at the next light, this is Webb Place • At the stop sign (in front of Starbucks), turn left • the office is 0.2 miles on your right in a brick building called Royal Commons. We are on the second floor.

Allergy Associates of NH Patient Registration Form

PATIENT INFORMATION **(Please Print)**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

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

Date of Birth ____/____/____ ☐ Female ☐ Male **Social Security Number** _____-_____- _____

Phone Numbers Home_____ Cell _____ Work_____

Preferred Number to Contact You ☐ Home ☐ Cell ☐ Work

Mailing Address_____ City, State, ZIP_____

Email _____ **May we send account information and statements via email?** ☐ Yes ☐ No

Physical Address (if different from mailing)_____

Primary Care Physician_____Address_____Phone number_____

Name of Pharmacy: _____City/Town_____Phone Number_____

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ Black/African American ☐ White/Caucasian

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Student ☐ Employed Full-Time ☐ Employed Part-Time ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____Relationship_____

List the names of your child's Parents/Guardians below if patient is under 18 years old.

Name:_____Rel:_____ Name:_____Rel:_____

RESPONSIBLE PARTY INFORMATION (complete if patient is under age 18) ***Statements will be addressed to the Responsible Party***

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

Date of Birth ____/____/____ ☐ Female ☐ Male **Social Security Number** _____-_____-_____

Phone Numbers Home_____ Cell_____ Work_____

Address_____

Employment Status ☐ Student ☐ Employed Full-Time ☐ Employed Part-Time ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Name of Subscriber_____ **Patient Relationship to Subscriber**_____

Date of Birth_____/_____/_____ Social Security Number _____-_____-_____

Phone Numbers: Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____ID#_____Group #_____

SECONDARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Name of Subscriber_____ **Patient Relationship to Subscriber**_____

Date of Birth_____/_____/_____ Social Security Number _____-_____-_____

Phone Numbers Home_____ Cell _____ Work_____

Address:_____City/State/Zip:_____

Insurance Plan Name:_____ID#_____Group #_____

Do we have permission to leave messages on your answering machine or with others who may answer your phone? ☐ Yes ☐ No

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize Allergy Associates of New Hampshire to submit claims to my insurance carrier and to release any medical information necessary to process claims. 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 that are denied for a lack of or valid referral.**

Patient (or Responsible Party) Signature_____ ***Date***_____

(Form must be signed)

Allergy Associates of New Hampshire
Allergy Questionnaire

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

Date: _____

Patient Name: _____ Date of Birth: _____

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

_____

_____

_____

_____

What makes is better? _____

What makes it worse? _____

What do you think causes the problem? _____

Most severe during: ☐ 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 ☐ 2 x month ☐ less

Number of 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)

Type of Medication	Name of Medication	Dosage	Frequency
Asthma Inhalers			
Antihistamines			
Nasal Sprays			
Eye Drops			
Steroids/Cortisone			
Other:			

Have you ever seen an allergist? ◯ Yes ◯ No Name: _____

Address: _____

Have you had xrays? sinus - ◯ Yes ◯ No chest - ◯ Yes ◯ No If yes, please obtain a copy of the report from your physician along with any corresponding chart notes.

Have you ever received allergy injections? ◯ Yes ◯ No

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Patient Name:_____ Date of Birth:_____

Please check any symptoms that *currently* bother you:

SKIN: ☐rash, ☐hives, ☐eczema, ☐blisters, ☐swelling, ☐burning, ☐redness, ☐itching, ☐white spots, ☐other _____
EYES: ☐tearing, ☐burning, ☐itching, ☐redness, ☐discharge, ☐puffiness, ☐vision problems, ☐pain, ☐other

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,
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

Please check 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, ☐other_____
ANIMALS: ☐dogs, ☐cats, ☐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, ☐stuffed toys, ☐fur, ☐rubber, ☐plastic, ☐other_____
INSECTS: type of reaction ☐hives, ☐trouble breathing, ☐other _____
EMOTIONS: ☐financial, ☐work related, ☐marital problems, ☐other _____

Do you have pets?
Dog ☐
Cat ☐
Other:_____

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Patient Name:_____ Date of Birth:_____

Family History

List names and occupations of individuals residing in house.

NAME	DATE OF BIRTH	OCCUPATION

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

Patient	Asthma	Hay Fever	Eczema	Hives	Other Lung Problems	Other Allergies
Grandmother						
Grandfather						
Mother						
Father						
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. _____

_____

Other medical problems: _____

Any known drug allergy?_____

Medications taken frequently including aspirin, birth control pills, vitamins, laxatives:_____

_____

Smoking History:

Have you ever smoked? ☐ Yes ☐ No If yes, for how many years?_____ Number of packs per day?_____

Do you still smoke? ☐ Yes ☐ No What year did you stop smoking?_____

Does anyone smoke in your home? ☐ Yes ☐ No

Medication List

Patient Name: ____ Date of Birth: _______________

Medication Name (include prescription and over the counter)	Dose (mg, units, drops)	When Taken (daily, at bedtime etc.)	Reason for Taking (asthma, blood pressure etc.)

Allergy Associates of New Hampshire

Notices and Disclosures

HIPAA Disclosure: A copy of the Allergy Associates of New Hampshire (AANH) Health Insurance Portability and Accountability Act (HIPAA) policy which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures is available to review upon request at the front desk of the business or on the website, allergiesnh.com. I acknowledge that I have been given an opportunity to read this policy. To the extent provided by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Patient or Parent/Guardian Signature: _____ Date: _____
(Form must be signed)

Disclosure to friends and/or family members:

We will automatically disclose information to your primary care provider and to parents of a child under the age of 18, they do not need to be listed below.

I give AANH permission to share all information relating to my medical care with the person(s) named below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Insurance: AANH participates with a wide variety of insurance companies and managed care plans. We will bill your insurance carrier as a courtesy to you. We recommend contacting your health insurance carrier to review your benefits and coverages prior to receiving services or treatment. Your insurance policy is a contract between you and your insurance company, AANH staff will not know the terms of your insurance policy. It is your responsibility to fully understand your insurance network, benefits, eligibility and to obtain and track referrals for your visits. Please note: We are not providers for Maine Medicaid. We cannot submit claims to insurance companies outside of the United States.

Fee Schedule: The following is an approximation of fees that may be charged.

Initial visit/consultation	$275.00 - $480.00
Prick tests	$ 13.00 ea. food/environmental $20.00 ea. insect $50.00 ea. medication
Intradermal tests	$ 16.00 ea. food/environmental $20.00 ea. insect $50.00 ea. medication

Financial Information: We will bill your insurance company as a courtesy to you. Any claim that is denied for lack of/invalid referral, invalid insurance information or otherwise not paid will be the patient responsibility. Copays are due at the time of service. Any amounts processed to deductible and co-insurance are due immediately upon statement receipt.

Appointments: If you need to cancel or change an appointment, please provide at least 24 hours notice. Appointments not cancelled with 24 hours notice can deny another patient the use of our services. We reserve the right to bill a fee of $50.00 for no show appointments and those not cancelled with at least 24 hours notice.

Communication: I grant permission for AANH, and its employees and agents, to call me at home, cell and work numbers listed on my patient information form, as updated by me, and if appropriate, to leave messages on any associated answering machine or voicemail, with information relating to my medical care; including, without limitation appointment, billing, medical and other information.

Thank you for understanding our Notices and Disclosures. Please let us know if you have any questions.
I have read, been advised of and agree to the foregoing Notices and Disclosures.

Patient Name: (please print)_____ Date: _____

Patient/Responsible Party Signature: _____ Relationship: _____
(Form must be signed)