220 WILSON STREET SUITE 200
CARLISLE, PA 17013
717 243-7540 Fax 717-243-9968

2025 TECHNOLOGY PKWY SUITE 310
MECHANICSBURG, PA 17050
717 791-2640 Fax 717-791-2646

4250 CRUMS MILL ROAD SUITE 200
HARRISBURG, PA 17112
717 920-4340 Fax 717-920-4341

# WELCOME TO OUR PRACTICE

## Medical Arts Allergy, P.C.

***www.medicalartsallergy.com***

## FOR ALL NEW PATIENTS

Prior to coming to our office, we would like you to take the time to read the following information. We have three offices. All offices, Carlisle, Mechanicsburg and Harrisburg, are open Monday through Thursday, 8 am to 5 pm, and Friday, 8:00 am to 4:30 pm.

The initial consult, physical and skin testing can take up to 3 hours. The consult and physical will be done before any allergy testing is done. **PLEASE BRING WITH YOU TO THIS VISIT ALL MEDICATIONS YOU ARE CURRENTLY TAKING. This will assure that all information concerning your medications are up to date in our records. PLEASE BRING WITH YOU OR HAVE SENT/FAXED TO US any recent medical records for the doctor to review: Chest x-rays, sinus x-rays, CT scans or breathing tests will be helpful. DO NOT BRING ACTUAL X-RAY FILMS, REPORTS ONLY.** Skin testing (by prick method) may be done at the first visit. You may have from (2) two tests up to eighty (80) tests done at this time. Most patients will have a return visit and a second set of tests. The second set of tests is usually done by the intradermal method.

**DO NOT TAKE ANY ANTIHISTAMINES OR DECONGESTANTS FOR ONE WEEK PRIOR TO YOUR APPOINTMENT. *These medications will affect the testing*. A listing of these medications is on the reverse side. If you are experiencing HIVES you may continue on your antihistamine until seen.**

## INFORMATION ON BILLING AND PAYMENT

**This information sheet is designed to help you understand the financial part of our practice.**

***COPAYS ARE DUE AT THE TIME OF YOUR VISIT.***

**If you do not pay your copay on the day of your visit, you may be charged a processing fee.**

**If services are not covered by your insurance** -- The initial consult fee is between $276.00 and $440.00 payable at the first visit. Testing, usually done at the first visit, ranges from 2 (two) tests up to 80 (eighty) tests done by the skin prick method with a charge of $10.00 per test.

Following the initial visit, a follow-up visit is usually scheduled for further testing and consultation with the doctor. This visit cost is between $70.00 and $178.00 with the number of tests ranging from 1 (one) test up to 30 (thirty) tests done by the intradermal method with a charge of $11.00 per test.
Our goal is to work with the patient in order to make a reasonable plan for payment of all balances. Our office policy is to have all balances paid within FOUR MONTHS of the first visit. Payment of 25% of any balance on a monthly basis is required. If this is a problem, we can set up an alternative payment plan.

***Not every insurance company covers skin testing or the consult/visit*.** We advise you to call your insurance company ***ahead of time*** to find out if you have coverage for allergy treatment, office visits, skin testing, and allergy injections. Procedure codes for skin testing are 95004, 95024, 95017 and 95018. If you have an HMO insurance, you must contact your PRIMARY CARE PHYSICIAN FOR A REFERRAL.
If you do not have a referral you will be responsible for all charges for that date of service. Your insurance company will also be able to tell you if this is a participating office.

***ALL PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY AN ADULT OR GUARDIAN.***

# MEDICAL ARTS ALLERGY, P.C.

Allergy Clinic Appointment Information

You have been scheduled for an appointment in the Allergy Clinic.

One aspect of this appointment may involve allergy skin testing. To ensure the accuracy of any diagnostic skin testing, please ensure you ***do not use any antihistamines in the 7 days preceding your appointment and certain other medications***. If you are experiencing HIVES you do not need to stop your antihistamine prior to your visit.

Refer to the list below.

| **Brand Name** | **(Generic Name)** |
|---|---|
| **Advil PM/Tylenol PM/Benadryl** | **diphenhydramine** |
| **Allegra** | **fexofenadine** |
| **Atarax** | **hydroxyzine** |
| **Atrohist** | **chorpheniramine** |
| **Bromfed** | **brompheniramine** |
| **Claritin** | **loratadine** |
| **Clarinex** | **desloratadine** |
| **Deconamine** | **chorpheniramine** |
| **Dimetapp** | **brompheniramine** |
| **Kronofed** | **chorpheniramine** |
| **Nolahist/Nolamine** | **phenindamine** |
| **Patanase** | **olopatadine** |
| **Periactin** | **cryoheptadine** |
| **Phenergan** | **promethazine** |
| **Rynatan/Rynatuss** | **chorpheniramine** |
| **Semprex** | **acrivastine** |
| **Sinulin** | **chorpheniramine** |
| **Trinalin** | **azatadine** |
| **Tylenol Sinus/Allergy** | **diphenhydramine** |
| **Vistaril** | **hydroxyzine** |
| **Xyzal** | **levocetirizine** |
| **Zyrtec** | **cetirizine** |

This list is not totally inclusive. Certain over-the-counter medications, especially “allergy” and “sinus” preparations, contain an antihistamine.

***In addition, some prescription antidepressant medications such as Pamelor, Trazodone, Doxepin, and Elavil, have antihistamine properties and will interfere with skin testing. Check with our office prior to stopping these medications.***

The following medications need to be stopped only 48 hours prior to your appointment:

| | |
|---|---|
| **Astelin/AstePro nasal spray** | **azelastine** |
| **Patanase** | **olopatadine** |
| **Patanol** | **olapatadine** |

**Nasal steroid sprays such as Flonase (fluticasone) and Nasonex do not interfere with allergy skin testing. You do not need to stop these medications before allergy skin testing.**

If you have any questions about using your medications prior to allergy skin testing, please call our office.

**MEDICAL ARTS ALLERGY, PC**

**www.medicalartsallergy.com**

**Jack L. Armstrong, MD  Donald S. Harper, MD**

**Krista M. Todoric, MD  Lauren W. Kaminsky, MD, PhD**

**Jodi L. Johnson, CRNP**

**APPT DATE: _____ARRIVAL TIME_____FOR A_____APPT**

**DR: _____ OFFICE: _____**

---

**Patient Information (Please Print)**

Patient Name: _____ Date of Birth _____

Address: _____City _____

State_____ Zip Code_____ Primary Phone _____ cell home work

Patient Sex M ☐ F ☐ Secondary Phone_____ cell home work

E-MAIL Address: _____

**Language:** (Please Check)

| | |
|---|---|
| English | |
| Spanish | |
| French | |
| German | |
| Vietnamese | |
| Italian | |
| Mandarin | |

**Race:** (Please Check)

| | |
|---|---|
| Asian(Chinese, Filipino, Japanese | |
| Black or African American | |
| Native Hawaiian or Othr Pacific Islander | |
| White | |
| American Indian or Alaska native | |
| Other (Pt declined, not any of the above | |

**Ethnicity:** **(Please Check)**

| | |
|---|---|
| Hispanic/Latino | |
| Non-Hispanic/Latino | |

**Marital Status:** **(PleaseCheck)**

| | |
|---|---|
| Single | |
| Married | |
| Separated | |
| Divorced | |
| Widow/er | |

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***Who may we thank for your referral? (**please check one**) Self_____ PCP _____ Other provider_____ (please list below)

**Referring Physician Name**: _____**Practice Name**:_____

*** **Primary Care Physician Name:** _____

Office Location/Practice Name: _____

---

**Contact in case of Emergency: _____Relationship to Patient: _____**

**Primay Phone#_____ Secondary Phone#_____**

| | | |
|---|---|---|
| **OVER** | **SIGNATURE REQUIRED ON BACK** | **OVER** |

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical and/or surgical benefits to which I am entitled including Private Insurance, Medicare, Blue Shield, HMO insurance and PPO insurance to MEDICAL ARTS ALLERGY, P.C. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible of all the charges whether or not paid by said insurance. I hereby authorize Medical Arts Allergy, P.C. to release all information necessary to secure the payment.

*******SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY FOR PATIENT) *******

**X_____DATE:_____**

_____

**If Patient is YOUR DEPENDENT, you must complete the following:**

YOUR NAME: _____

Address_____ Your relationship to Patient: _____

_____ Social Security No: _____

Birthdate: _____ Sex ☐ M ☐ F

Phone# _____ Cell Phone # _____

**PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY AN ADULT FOR VISITS AND ADMINISTRATION OF ALL INJECTIONS.**

_____

## Pharmacy Information

Pharmacy #1_____Phone:_____

Address_____

Pharmacy #2_____Phone:_____

Address_____

**My signature here indicates that I authorize Medical Arts Allergy to receive medication reconciliation through the pharmacy reconciliation network for a listing of my current medications:**

**X_____Date:_____**

# Insurance Information

**Please show insurance cards on arrival**

**PATIENT NAME: _____DOB:_____**

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## Primary Insurance

Policy ID#_____ Group #_____

Name of Insurance Company_____ Employer of Policy Holder_____

Name of Policy Holder_____ Relationship to Patient_____

Policy Holder address: _____ Policy Holder Phone#_____

_____ Policy Holder Birthday: _____

Policy Holder SSN#:_____ Policy Holder Sex: ☐ M ☐ F

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## Secondary Insurance

Policy ID#_____ Group #_____

Name of Insurance Company_____ Employer of Policy Holder_____

Name of Policy Holder_____ Relationship to Patient_____

Policy Holder address: _____ Policy Holder Phone#_____

_____ Policy Holder Birthday: _____

Policy Holder SSN#:_____ Policy Holder Sex: ☐ M ☐ F

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## Tertiary Insurance

Policy ID#_____ Group #_____

Name of Insurance Company_____ Employer of Policy Holder_____

Name of Policy Holder_____ Relationship to Patient_____

Policy Holder address: _____ Policy Holder Phone#_____

_____ Policy Holder Birthday: _____

Policy Holder SSN#:_____ Policy Holder Sex: ☐ M ☐ F

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

## Prescription Card – If you have a prescription card please show to receptionist at check in.

**PLEASE READ AND SIGN THE BACK OF THIS FORM**
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

**Welcome to our practice.**
**This information sheet is designed to help you to understand the financial part of our practice.**

Your signature here indicates that you have read the following information regarding our fees and payment policy.

**X_____Date:_____**

**COPAYS ARE DUE AT THE TIME OF YOUR VISIT.**

**If you do not pay your copay on the day of your visit, you may be charged a processing fee**

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**If services are not covered by your insurance--** The initial consult fee is between $276.00 and $440.00 payable at the first visit. Testing, usually done at the first visit, ranges from 1(one) test up to 80 (eighty) tests done by the skin prick method with a charge of $10.00 per test.

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**Not every insurance covers skin testing or the consult/visit.** We advise you to call your insurance company **ahead of time** to find out if you have coverage for allergy treatment, office visits, skin testing, and allergy injections. Procedure codes for skin testing are 95004, 95024, 95017and 95018. If you have an HMO insurance, you must contact your **PRIMARY CARE PHYSICIAN FOR A REFERRAL.** If you do not have a referral you will be responsible for all charges for that date of service. Your insurance company will also be able to tell you if this is a participating office.

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We will provide the service of submission to any insurance company provided you have given all pertinent information, **however, the PATIENT is responsible for balances that are outstanding beyond 60 DAYS from the date of service.**

This office does accept MasterCard, Visa ,Discover and American Express cards for payment of services. If your account should require collection or litigation, any and all additional cost would be the responsibility of the patient. If you have any questions, please feel free to contact us.

# MEDICAL ARTS ALLERGY, PC
# New Patient Questionnaire

## PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Referring Physician: Primary Physician:

## PURPOSE OF EVALUATION: *What is your primary concern, and what do you hope to accomplish with this evaluation?*

## ALLERGY HISTORY:

### *Chest & Breathing Symptoms*

| Yes | No | | AGE OF ONSET OF SYMPTOMS | PLEASE CIRCLE MONTHS WHEN SYMPTOMS ARE MOST SEVERE |
|---|---|---|---|---|
| ☐ | ☐ | Chest tightness | | J F M A M J J A S O N D |
| ☐ | ☐ | Shortness of breath | ☐ Childhood | |
| ☐ | ☐ | Wheezing | ☐ Adulthood | **Because of breathing trouble, have you ever… If so, list date(s)…** |
| ☐ | ☐ | Coughing | | Been to the emergency room? ☐ yes ☐ no |
| | | | | Been admitted to the hospital? ☐ yes ☐ no |
| | | | | Been given oral steroids? ☐ yes ☐ no |

What makes your symptoms *worse*?

What makes your symptoms *better*?

Notes

### *Nose & Sinus Symptoms*

| Yes | No | | AGE OF ONSET OF SYMPTOMS | PLEASE CIRCLE MONTHS WHEN SYMPTOMS ARE MOST SEVERE |
|---|---|---|---|---|
| ☐ | ☐ | *Nasal Polyps | | J F M A M J J A S O N D |
| ☐ | ☐ | Congested nose | ☐ Childhood | |
| ☐ | ☐ | Runny nose | ☐ Adulthood | **Have you ever had a sinus CT?** ☐ yes ☐ no |
| ☐ | ☐ | Sneezing | | |
| ☐ | ☐ | Post-nasal drip | | |
| ☐ | ☐ | Itchy mouth/throat | | |
| ☐ | ☐ | Sore throat | | |

What makes your symptoms *worse*?

What makes your symptoms *better*?

Notes

### *Ear & Eye Symptoms*

| Yes | No | | AGE OF ONSET OF SYMPTOMS | PLEASE CIRCLE MONTHS WHEN SYMPTOMS ARE MOST SEVERE |
|---|---|---|---|---|
| ☐ | ☐ | Itchy ears | | J F M A M J J A S O N D |
| ☐ | ☐ | Clogged ears | ☐ Childhood | |
| ☐ | ☐ | Burning eyes | ☐ Adulthood | |
| ☐ | ☐ | Itchy eyes | | |
| ☐ | ☐ | Red eyes | | |
| ☐ | ☐ | Watery eyes | | |

What makes your symptoms *worse*?

What makes your symptoms *better*?

Notes

# MEDICAL ARTS ALLERGY, PC

## *Skin Symptoms*

| Yes | No | | AGE OF ONSET OF SYMPTOMS | PLEASE CIRCLE MONTHS WHEN YOUR SYMPTOMS ARE MOST SEVERE |
|---|---|---|---|---|
| ☐ | ☐ | Redness | | J F M A M J J A S O N D |
| ☐ | ☐ | Dryness | ☐ Childhood | |
| ☐ | ☐ | Itching | ☐ Adulthood | **Have you ever…** |
| ☐ | ☐ | *Eczema | | Had patch testing done? ☐ yes ☐ no |
| ☐ | ☐ | *Hives | | Had a skin biopsy? ☐ yes ☐ no |
| ☐ | ☐ | *Swelling | | |

What makes your symptoms *worse*?

What makes your symptoms *better*?

Notes

## *Recurrent Infections*

| Yes | No | | AGE OF ONSET OF SYMPTOMS | NUMBER OF INFECTIONS REQUIRING ANTIBIOTICS | |
|---|---|---|---|---|---|
| | | | | In your LIFETIME | In the PAST YEAR |
| ☐ | ☐ | Ear Infections | | | |
| ☐ | ☐ | Sinus Infections | | | |
| ☐ | ☐ | Lung Infections | | | |
| ☐ | ☐ | Skin Infections (not acne) | | | |

## *Other Allergies*

| Yes | No | | AGE OF ONSET OF SYMPTOMS | PLEASE PROVIDE DETAILS (DATE OF REACTION, SYMPTOMS…) |
|---|---|---|---|---|
| ☐ | ☐ | Medications | | |
| ☐ | ☐ | Foods | | |
| ☐ | ☐ | Insect Stings | | |
| ☐ | ☐ | Latex | | |
| ☐ | ☐ | Metals (such as jewelry) | | |
| ☐ | ☐ | Soaps, Lotions, Perfumes | | |
| ☐ | ☐ | Immunizations | | |

## PREVIOUS ALLERGY EVALUATION & TREATMENT: *If possible, please provide us with copies of these records.*

Have you had **allergy skin tests or blood tests** before? ☐ Yes ☐ No *If yes, date:* _____

Results _____

Have you received **allergy immunotherapy (allergy shots)** before? ☐ Yes ☐ *No* *If yes, dates* _____

## IMMUNIZATIONS (list date last received):

Tetanus _____ Pneumovax 23 _____ Prevnar 13 _____

Flu _____ Shingles _____

Covid 19 manufacturer _____ 1st _____ 2nd _____ Booster _____

# MEDICAL ARTS ALLERGY, PC

## CURRENT MEDICATIONS: *Please include over-the-counter medications, vitamins and supplements.*

## NEWBORN HISTORY (ONLY COMPLETE IF PATIENT <18 YEARS OLD):

Did mom have any complications with pregnancy? ☐ Yes ☐ No If yes, what _____

Was baby born full term? ☐ Yes ☐ No If no, how early _____

Where there any complications at delivery? ☐ Yes ☐ No If yes, what _____

Did baby spend time in the intensive care unit? ☐ Yes ☐ No If yes, how long _____

Feedings: Breastmilk ☐ Formula ☐ Breastmilk/Formula ☐ Introduced solid food at _____ months

## MEDICAL HISTORY:

| | Never | Current | Past | | Never | Current | Past |
|---|---|---|---|---|---|---|---|
| **EARS/EYES** | | | | **ENDOCRINOLOGY** | | | |
| Hearing loss | | | | Diabetes | | | |
| Cataracts | | | | Thyroid disease | | | |
| Glaucoma | | | | **RHEUMATOLOGY/MSK** | | | |
| Retina disease | | | | Fibromyalgia | | | |
| Vision loss | | | | Osteoarthritis | | | |
| **CARDIOVASCULAR** | | | | Osteoporosis | | | |
| High blood pressure | | | | Lupus | | | |
| High cholesterol | | | | Rheumatoid arthritis | | | |
| Heart disease | | | | **HEMATOLOGY/ONCOLOGY** | | | |
| Heart murmur | | | | Anemia | | | |
| **PULMONARY** | | | | Cancer | | | |
| Emphysema/COPD | | | | **NEUROLOGICAL** | | | |
| Sarcoidosis | | | | Dementia | | | |
| Pulmonary hypertension | | | | Headache | | | |
| Pulmonary fibrosis | | | | Migraines | | | |
| **GASTROENTEROLOGY** | | | | Seizures | | | |
| Crohn's disease | | | | Stroke | | | |
| Gastroparesis | | | | **DERMATOLOGY** | | | |
| Hiatal hernia | | | | Psoriasis | | | |
| Heartburn/reflux | | | | **PSYCHIATRIC** | | | |
| Liver Disease | | | | Anxiety | | | |
| Ulcerative colitis | | | | Depression | | | |
| **GENITOURINARY** | | | | **INFECTIOUS DISEASES** | | | |
| Enlarged prostate | | | | Hepatitis | | | |
| Kidney disease | | | | HIV | | | |

*Please list any active medical problems or details not included above.*

## SURGERIES:

# MEDICAL ARTS ALLERGY, PC

## FAMILY HISTORY:

| Age(s)/Gender(s) | Please list pertinent allergy/immunology-related medical problems, including asthma, seasonal allergies, food allergy, autoimmune diseases, immunodeficiencies, genetic disorders |
|---|---|
| Father | |
| Mother | |
| Siblings | |
| | |
| | |

## SOCIAL HISTORY:

Are you ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Do you have any children? ☐ Yes ☐ No If so, how many? _____

Do you smoke? ☐ Yes ☐ No, never ☐ No, I started when I was _____ years old and quit when I was _____ years old.

If yes, type ☐ Cigarettes ☐ E-cigarettes ☐ Other

If you ever smoked, what was the highest number of cigarettes per day? _____ pack

Does anyone you live with smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week on average? _____ drinks

Occupation / School Grade: _____

List the state/country where you were born _____

Please list any pets you own (dogs, cats, birds, horses, gerbils …)

Indoor: _____

Outdoor: _____

## SUBSPECIALISTS: Do you see any of the following….

| Yes | No | Specialty | Name/Practice, Location | Date Last Seen |
|---|---|---|---|---|
| | | Allergy/Immunology | | |
| | | Dermatology | | |
| | | Ear, Nose, Throat (ENT) | | |
| | | Gastroenterology | | |
| | | Hematology | | |
| | | Ophthalmology | | |
| | | Pulmonology | | |
| | | Rheumatology | | |

_____ _____

Signature of Patient (or representative) Date Signature of Reviewing Physician/NP/PA Date