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

FREDRICKSEN OUTPATIENT CTR
2025 TECHNOLOGY PKWY – SUITE 310
MECHANICSBURG, PA 17050
717 791-2640 Fax 717-791-2646

BLOOM OUTPATIENT BLDG
4310 LONDONDERRY RD STE 201
HARRISBURG, PA 17109
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, short physical and skin testing will take approximately 1 ½ to 2 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 sixty (60) 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 1 (one) test up to 60 (sixty) 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 no 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 the Allergy Clinic.

Carlisle: 717-243-7540 Mechanicsburg: 717-791-2640 Harrisburg: 717-920-4340

MEDICAL ARTS ALLERGY, P.C.

Jack L. Armstrong M.D.
D. Scott Harper M.D. Helen C. Wang M.D.
Miae Oh M.D. Jodi Johnson C.R.N.P.

APPT DATE: _____ARRIVAL TIME_____FOR A_____APPT

DR: _____ OFFICE: _____

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www.medicalartsallergy.com

Patient Information (Please Print)

Patient Name: _____Social Security No._____

Address: _____ Patient Employer_____

City _____State_____ Work Phone#_____

Zip Code _____Home Phone# _____ Cell Phone#_____

E-MAIL Address: _____

Patient Sex M☐ F ☐ Birthdate_____ Student Status (PT/FT) _____

Language: (Please Check)

English	
Spanish	
French	
German	
Vietnamese	
Italian	
Mandarin	

Race: (Please Check)

Asian (Chinese, Filipino, Japanese)		White	
Black or African American		American Indian or Alaska Native	
Native Hawaiian or Other Pacific Islander		Other (Pt. Declined, Not any of the above)	

Ethnicity: (Please Check)

Hispanic/Latino	
Non Hispanic/Latino	

MaritalStatus: (PleaseCheck)

Single	
Married	
Separated	
Divorced	
Widow/er	

***Referring Physician Name**: _____Phone#_____

Office Location/Practice Name: _____

*** **Primary Care Physician Name:** _____ Phone#_____

Office Location/Practice Name: _____

Contact in case of Emergency: _____Relationship to Patient: _____

Phone#_____ Alternate Phone#_____ Text: Y ☐ N ☐

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:_____

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

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

PLEASE READ AND SIGN THE BACK OF THIS FORM
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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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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 and Discover 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.

Carlisle 243-7540 **Mechanicsburg 791-2640** **Harrisburg 920-4340**

MEDICAL ARTS ALLERGY, PC

ALLERGY AND CLINICAL IMMUNOLOGY QUESTIONNAIRE

Please bring the completed form with you to your appointment

PATIENT INFORMATION:

Please answer the following questions as they apply to the patient Appointment Date:

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: *Please tell us about your allergy symptoms; Mark all that apply.*

Chest & Breathing Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Asthma		J F M A M J J A S O N D
☐	☐	Wheezing		J F M A M J J A S O N D
☐	☐	Cough		J F M A M J J A S O N D
☐	☐	Chest tightness / pain		J F M A M J J A S O N D
☐	☐	Bronchitis		J F M A M J J A S O N D

What triggers your symptoms or makes your chest & breathing symptoms worse?

What makes your chest & breathing symptoms better?

Nose & Sinus Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Runny nose		J F M A M J J A S O N D
☐	☐	Post-nasal drip		J F M A M J J A S O N D
☐	☐	Sneezing		J F M A M J J A S O N D
☐	☐	Congestion		J F M A M J J A S O N D
☐	☐	Sinusitis		J F M A M J J A S O N D

What triggers your symptoms or makes your nasal & sinus symptoms worse?

What makes your nasal & sinus symptoms better?

Eye Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Itchy / swollen eyes		J F M A M J J A S O N D
☐	☐	Irritated / burning eyes		J F M A M J J A S O N D
☐	☐	Dry eyes		J F M A M J J A S O N D
☐	☐	Teary eyes		J F M A M J J A S O N D

What triggers your symptoms or makes your eye symptoms worse?

What makes your eye symptoms better?

Skin Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Hives		J F M A M J J A S O N D
☐	☐	Eczema / atopic dermatitis		J F M A M J J A S O N D
☐	☐	Swollen lips / tongue		J F M A M J J A S O N D
☐	☐	Swollen face / hands / feet		J F M A M J J A S O N D

What triggers your symptoms or makes your skin symptoms worse?

What makes your skin symptoms better?

Recurrent Infections

Yes	No		Age of onset	Please provide details (date of last infection, times per year, antibiotic use)
☐	☐	Ear Infections		
☐	☐	Sinus Infections		
☐	☐	Lung Infections		
☐	☐	Skin Infections (other than acne)		

Have you experienced other severe or repeated infections? (Please provide details)

Have you required hospital treatment (overnight) for your infections? (Please provide details)

Other Allergies

Yes	No		Age of onset	Please provide details (date of reaction, symptoms…)
☐	☐	Medications		
☐	☐	Foods		
☐	☐	Insect Stings		
☐	☐	Latex		
☐	☐	Metals (such as jewelry)		
☐	☐	Soaps, Lotions, Perfumes		

Have you experienced other allergic reactions? (Please provide details)

CURRENT MEDICATIONS: *Please list medications and doses (include over-the-counter medications, vitamins and supplements).*

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

Have you had **allergy skin tests** before?

☐ Yes ☐ No *If yes*, Date: _____ Physician: _____

Results: _____

Have you had **allergy blood tests (RAST**) before?

☐ Yes ☐ No *If yes*, Date: _____ Physician: _____

Results: _____

Have you received **allergy immunotherapy (allergy shots)** before?

☐ Yes ☐ No *If yes*, Date: _____ Physician: _____

Clinical Response: _____

IMMUNIZATIONS HISTORY: *(Please provide copies of vaccine records if available)*

Have you experienced any serious reaction to a vaccine? ☐ Yes ☐ No *if Yes, details:* _____

Year of your last: Flu vaccine: _____

NEWBORN HISTORY: *(If the patient is less than 18 years old)*

Was there any difficulty while the mother was pregnant with the patient? ☐ Yes ☐ No

Was the patient delivered without difficulty? ☐ Yes ☐ No

Was breathing assistance required at delivery? ☐ Yes ☐ No

Did the patient go to the regular nursery? ☐ Yes ☐ No

Did the patient require intensive care? ☐ Yes ☐ No

Feedings: Breast ☐ Yes ☐ No If yes, until age? _____

Formula ☐ Yes ☐ No If yes, until what age? _____

Solid foods were started at what age? _____

Any concerning events for the baby during birth? Please explain: _____

MEDICAL HISTORY: *Have you ever had, or do you currently have any of the following?*

	Never	Current	Past		Never	Current	Past
High or low blood pressure				Anxiety			
Coronary artery disease / angina				Migraine headaches			
Mitral valve prolapse				Sinus headaches			
Heart murmur				Tension headaches			
Stroke				Epilepsy / seizures			
Rheumatic fever				Glaucoma			
Thyroid disease				Cataracts			
Liver disease				Emphysema			
Infectious hepatitis (liver infection)				Tuberculosis			
Kidney disease				Rheumatoid arthritis			
Bladder trouble				Osteoarthritis or joint replacement			
Prostate trouble (men)				Lupus			
Stomach trouble or ulcers				Diabetes or elevated blood sugar			
Heart burn or esophageal reflux				HIV or Aids			
Depression				Cancer (please provide details)			

Do you have any other active medical problems not listed above? (Please provide details)

SURGERIES: *Please list the most recent along with reason and date.*

HOSPITALIZATIONS: *Please list the most recent along with reason and date.*

FAMILY HISTORY: *Tell us about any diseases (especially asthma, allergies, eczema…) that run in your family.*

	Age	Medical diagnoses	If deceased, at what age?
Father			
Mother			
Siblings (ages & genders)			
Children (ages & genders)			

SOCIAL HISTORY: *Please tell us about your habits and hobbies.*

Tobacco:

Do you smoke? ☐ Current ☐ Former - Year Quit _____ ☐ No, Never Does anyone you live with smoke? ☐ Yes ☐ No

Type of Cigarettes smoked: ☐ E-cigarettes/vaping ☐ Cigarettes

If you ever smoked, what was the highest number of cigarettes per day? _____, how long did you smoke? _____

If you now smoke, have you quit in the past? ☐ Yes ☐ No Are you considering quitting? ☐ Yes ☐ No

Are you regularly exposed to passive (second-hand) tobacco smoke? ☐ Yes ☐ No

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

Hobbies: _____

Occupation / School Grade: _____

How many days have you missed from work / school because of your allergy symptoms?

If Child: Does the patient live in more than one home?

ENVIRONMENTAL SURVEY: *Please tell us about where you live and work.*

Past & Current Residences - *Please list most recent residence first*

	City, State	*Years*	*Effect on symptoms (better, worse, no change)*
1.			
2.			
3.			

What type of dwelling do you currently reside in? ☐ Single family ☐ Mobile home ☐ Town home / Condo ☐ Apartment / Dorm

How old is your current residence? _____ How long have you lived there? _____

Home construction (brick, wood…) _____ Neighborhood? ☐ urban / city ☐ rural / farm ☐ suburban

Any nearby industrial plants? _____ Any nearby agricultural operations? _____

How is your home heated? _____ How is your home cooled? _____

Carpeting: ☐ None ☐ Area rugs only ☐ Wall to wall Carpet type (synthetic, wool …) _____

Are there any damp or musty rooms? ☐ Yes ☐ No Do you have a ☐ Air Filter ☐ Dehumidifier ☐ Humidifier

How old is your pillow? _____ check details: ☐ Feather ☐ Dacron ☐ Foam ☐ Allergy-barrier encased

How old is your mattress? _____ check details: ☐ Waterbed ☐ Foam ☐ Innerspring ☐ Allergy-barrier encased

Please list any pets you own and how many. (dogs, cats, birds, horses, gerbils …)

Are your pets allowed into the bedroom? ☐ Yes ☐ No

Indoor Pets: _____

Outdoor Pets: _____

⇨ _____ _____

Signature of Patient (or patient representative) ***Date*** ***Signature of Reviewing Provider*** ***Date***

MEDICAL ARTS ALLERGY, P.C.

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4310 Londonderry Road, Suite 201
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Additional Asthma Details

(Please answer as applicable to the patient)

Asthma History

Have you been in the ER because of asthma? ☐ Yes ☐ No

Details: _____

_____

Have you been hospitalized because of asthma? ☐ Yes ☐ No

Details: _____

_____

Have you been admitted to the intensive care unit because of asthma? ☐ Yes ☐ No

Details: _____

_____

Do you have a nebulizer (breathing machine) at home? ☐ Yes ☐ No

Do you have a peak flow meter at home? ☐ Yes ☐ No

Have you ever participated in an asthma education class? ☐ Yes ☐ No

Asthma Control Test

On **average**, over the past **4 weeks…**

1. How much of the time did your asthma keep you from getting as much done at work, school or at home?
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

2. How often have you had shortness of breath?
☐ More than once a day ☐ Once a day ☐ 3-6 times a week ☐ 1-2 times a week ☐ Not at all

3. How often did your asthma symptoms wake you up at night or earlier than usual in the morning?
☐ 4 or more nights a week ☐ 2-3 nights a week ☐ Once a week ☐ Once or twice ☐ Not at all

4. How often have you used your rescue inhaler (albuterol, Maxair..) or nebulizer medication (albuterol, Xopenex…)?
☐ 3 or more times/day ☐ 1-2 times/day ☐ 2-3 times/week ☐ Once/week (or less) ☐ Not at all

5. How well would you rate your **asthma** control during the past **4 weeks**?
☐ Not controlled at all ☐ Poorly controlled ☐ Somewhat controlled ☐ Well controlled ☐ Completely controlled