

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.

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.

<u>Brand Name</u>	<u>(Generic Name)</u>
Advil PM/Tylenol PM/Benadryl	diphenhydramine
Allegra	fexofenadine
Atarax	hydroxyzine
Atrohist	chlorpheniramine
Bromfed	brompheniramine
Claritin	loratadine
Clarinx	desloratadine
Deconamine	chlorpheniramine
Dimetapp	brompheniramine
Kronofed	chlorpheniramine
Nolahist/Nolamine	phenindamine
Patanase	olopatadine
Periactin	cryoeptadine
Phenergan	promethazine
Rynatan/Rynatuss	chlorpheniramine
Semprex	acrivastine
Sinulin	chlorpheniramine
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:

Astelín/AstePro nasal spray	azelastine
Patanase	olopatadine
Patanol	olopatadine

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

Do Not Use Medications Revised 12-2-15 eas

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:** _____

www.medicalartsallergy.com

Patient Information (Please Print)

Patient Name: _____ Date of Birth _____

Address: _____ Social Security No. _____

City _____ State _____ Work Phone# _____

Zip Code _____ Home Phone# _____ Cell Phone# _____

E-MAIL Address: _____

Patient Sex M F

Language: (Please Check)

Race: (Please Check)

Ethnicity: (Please Check)

MaritalStatus: (PleaseCheck)

English
Spanish
French
German
Vietnames
Italian
Mandarin

Asian (Chinese, Filipino, Japanese)
Black or African American
Native Hawaiian or Other Pacific Islander

White
Ame Alasl
Othe any of

Hispanic/Latinc
Non Hispanic/L

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
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New Patient Demo Pkt 4/25/17 eas

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:** _____

New Patient Demo Pkt 6-25-15 eas

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**

New Patient Demo Pkt 6-25-15 e

New Patient Demo Pkt 6-25-15 eas

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

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

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**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 60(sixty) tests done by the skin prick method with a charge of \$10.00 per test.

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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**

New Patient Demo Pkt 6-25-15 eas

## 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?*

|                          |                          |                        |   |   |   |   |   |   |   |   |   |   |   |   |
|--------------------------|--------------------------|------------------------|---|---|---|---|---|---|---|---|---|---|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                 | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing               | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough                  | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest tightness / pain | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?*

|                          |                          |                 |   |   |   |   |   |   |   |   |   |   |   |   |
|--------------------------|--------------------------|-----------------|---|---|---|---|---|---|---|---|---|---|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Runny nose      | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Post-nasal drip | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Sneezing        | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Congestion      | J | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | 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             | <i>(Please circle)</i><br>Which months are your symptoms most severe? |   |   |   |   |   |   |   |   |   |   |   |
|--------------------------|--------------------------|--------------------------|-----------------------------------------------------------------------|---|---|---|---|---|---|---|---|---|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy / swollen eyes     | J                                                                     | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritated / burning eyes | J                                                                     | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry eyes                 | J                                                                     | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | 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                | <i>(Please circle)</i><br>Which months are your symptoms most severe? |   |   |   |   |   |   |   |   |   |   |   |
|--------------------------|--------------------------|-----------------------------|-----------------------------------------------------------------------|---|---|---|---|---|---|---|---|---|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hives                       | J                                                                     | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema / atopic dermatitis  | J                                                                     | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen lips / tongue       | J                                                                     | F | M | A | M | J | J | A | S | O | N | D |
| <input type="checkbox"/> | <input type="checkbox"/> | 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) |
|--------------------------|--------------------------|------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Infections   |                                                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | 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).

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

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

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**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)

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Children (ages & genders)

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**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.**

Medical Arts Building  
220 Wilson Street, Suite 200  
Carlisle, PA 17013  
(717) 243-7540 Fax: (717)  
243-9968

Fredricksen Outpatient Center  
2025 Technology Parkway, Suite 310  
Mechanicsburg, PA 17050  
(717) 791-2640 Fax: (717) 791-2646

Bloom Outpatient Building  
4310 Londonderry Road, Suite 201  
Harrisburg, PA 17109  
(717) 920-4340 Fax: (717) 920-4341

**Additional Asthma Details**

(Please answer as applicable to the patient)

**Asthma History**

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

Details: \_\_\_\_\_

No

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Have you been hospitalized because of asthma?

Yes  No

Details:

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Have you been admitted to the intensive care unit because of asthma?

Yes  No

Details:

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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