

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

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.medicalartsalergy.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 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 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.

<u>Brand Name</u>	<u>(Generic Name)</u>
Advil PM/Tylenol PM/Benadryl	diphenhydramine
Allegra	fexofenadine
Atarax	hydroxyzine
Atrohist	chlorpheniramine
Bromfed	brompheniramine
Claritin	loratadine
Clarinex	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:

Astelin/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 our office.

Carlisle: 717-243-7540

Mechanicsburg: 717-791-2640

Harrisburg: 717-920-4340

MEDICAL ARTS ALLERGY, PC

www.medicalartsallergy.com

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

Krista M. Todoric, MD 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)

Race: (Please Check)

Ethnicity: (Please Check)

Marital Status: (Please Check)

English	<input type="checkbox"/>
Spanish	<input type="checkbox"/>
French	<input type="checkbox"/>
German	<input type="checkbox"/>
Vietnamese	<input type="checkbox"/>
Italian	<input type="checkbox"/>
Mandarin	<input type="checkbox"/>

Asian(Chinese, Filipino, Japanese)	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>
Native Hawaiian or Othr Pacific Islander	<input type="checkbox"/>
White	<input type="checkbox"/>
American Indian or Alaska native	<input type="checkbox"/>
Other (Pt declined, not any of the above)	<input type="checkbox"/>

Hispanic/Latino	<input type="checkbox"/>
Non-Hispanic/Latino	<input type="checkbox"/>

Single	<input type="checkbox"/>
Married	<input type="checkbox"/>
Separated	<input type="checkbox"/>
Divorced	<input type="checkbox"/>
Widow/er	<input type="checkbox"/>

***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
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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

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

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.

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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, 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.

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 do you hope to accomplish with this evaluation?

ALLERGY HISTORY:

Chest & Breathing Symptoms

Yes	No		Age of onset	Please circle months when your symptoms are most severe
<input type="checkbox"/>	<input type="checkbox"/>	Chest congestion		J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath		J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing		
<input type="checkbox"/>	<input type="checkbox"/>	Coughing		
<input type="checkbox"/>	<input type="checkbox"/>	*Coughing up blood		Because of breathing trouble, have you ever... If so, when...
<input type="checkbox"/>	<input type="checkbox"/>	*Shortness of breath when lying flat		Been to the emergency room? <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/>	<input type="checkbox"/>	*Shortness of breath with exertion		Been admitted to the hospital? <input type="checkbox"/> yes <input type="checkbox"/> no
What makes your symptoms worse?				Been intubated (breathing tube)? <input type="checkbox"/> yes <input type="checkbox"/> no
				Been given oral steroids? <input type="checkbox"/> yes <input type="checkbox"/> no

What makes your symptoms better?

Nose & Sinus Symptoms

Yes	No		Age of onset	Please circle months when your symptoms are most severe
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds		J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Itchy nose		J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Congested nose		
<input type="checkbox"/>	<input type="checkbox"/>	Runny nose		
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing		Have you ever had a sinus CT? <input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip		
<input type="checkbox"/>	<input type="checkbox"/>	Itchy throat		
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat		
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness		
<input type="checkbox"/>	<input type="checkbox"/>	Cough		
<input type="checkbox"/>	<input type="checkbox"/>	*Snoring		

What makes your symptoms worse?

What makes your symptoms better?

Ear & Eye Symptoms

Yes	No		Age of onset	Please circle months when your symptoms are most severe
<input type="checkbox"/>	<input type="checkbox"/>	Itchy ears		J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Popping ears		J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Burning eyes		
<input type="checkbox"/>	<input type="checkbox"/>	Itchy eyes		
<input type="checkbox"/>	<input type="checkbox"/>	Red eyes		
<input type="checkbox"/>	<input type="checkbox"/>	Watery eyes		
<input type="checkbox"/>	<input type="checkbox"/>	Dark circles under eyes		
<input type="checkbox"/>	<input type="checkbox"/>	*Vision change		
<input type="checkbox"/>	<input type="checkbox"/>	*Hearing loss		
<input type="checkbox"/>	<input type="checkbox"/>	*Ringing in ears		
<input type="checkbox"/>	<input type="checkbox"/>	*Plugged ears		

What makes your symptoms worse?

What makes your symptoms better?

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Skin Symptoms					
Yes	No		Age of onset	Please circle months when your symptoms are most severe	
<input type="checkbox"/>	<input type="checkbox"/>	Roughness		J	F
<input type="checkbox"/>	<input type="checkbox"/>	Redness		M	A
<input type="checkbox"/>	<input type="checkbox"/>	Dryness		M	J
<input type="checkbox"/>	<input type="checkbox"/>	Itching		J	J
<input type="checkbox"/>	<input type="checkbox"/>	*Hives		A	S
<input type="checkbox"/>	<input type="checkbox"/>	*Swelling		O	N
Have you ever... Had patch testing done? <input type="checkbox"/> yes <input type="checkbox"/> no Had a skin biopsy? <input type="checkbox"/> yes <input type="checkbox"/> no					
What makes your symptoms <i>worse</i> ?					
What makes your symptoms <i>better</i> ?					

Recurrent Infections			Number of Infections requiring antibiotics	
Yes	No		In your LIFETIME	In the PAST YEAR
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections		
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infections		
<input type="checkbox"/>	<input type="checkbox"/>	Lung Infections		
<input type="checkbox"/>	<input type="checkbox"/>	Skin Infections (not acne)		
<input type="checkbox"/>	<input type="checkbox"/>	OTHER		

Other Allergies			
Yes	No	Age of onset	Please provide details (date of reaction, symptoms...)
<input type="checkbox"/>	<input type="checkbox"/>	Medications	
<input type="checkbox"/>	<input type="checkbox"/>	Foods	
<input type="checkbox"/>	<input type="checkbox"/>	Insect Stings	
<input type="checkbox"/>	<input type="checkbox"/>	Latex	
<input type="checkbox"/>	<input type="checkbox"/>	Metals (such as jewelry)	
<input type="checkbox"/>	<input type="checkbox"/>	Soaps, Lotions, Perfumes	
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations	
<input type="checkbox"/>	<input type="checkbox"/>	OTHER	

PREVIOUS ALLERGY EVALUATION & TREATMENT: <i>If possible, please provide us with copies of these records.</i>	
Have you had allergy skin tests or blood tests before?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date:</i> _____
Results _____	
Have you received allergy immunotherapy (allergy shots) before?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, dates</i> _____
IMMUNIZATIONS (list date last received):	
Tetanus _____	Pneumovax 23 _____
Flu _____	Covid 19 _____
	Prevnar 13 _____
	Shingles _____

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

NEWBORN HISTORY (complete if patient <18 years old):

Did mom have any complications with pregnancy? Yes No
 Where there any complications at delivery? Yes No Was baby born full term? Yes No
 Did baby spend time in the intensive care unit? Yes No If no, how early _____?
 Feedings: Breastmilk Formula Breastmilk/Formula Introduced solid food at _____ months

MEDICAL HISTORY:

	Never	Current	Past		Never	Current	Past
Anemia				Migraines			
Anxiety				Hepatitis			
Asthma				High blood pressure			
Cancer				HIV			
Cataracts				Kidney disease			
Crohn's disease				Liver disease			
Dementia				Lupus			
Depression				Nasal polyps			
Diabetes				Osteoarthritis			
Eczema				Psoriasis			
Emphysema/COPD				Retina disease			
Enlarged prostate				Rheumatoid arthritis			
Food allergies				Seasonal allergies			
Gastroparesis				Seizures			
Glaucoma				Thyroid disease			
Headache				Urinary incontinence			
Heart attack				Vision loss			
Heart disease				Sarcoidosis			
Heart murmur				Stroke			
Hearing loss				Ulcerative colitis			
Heartburn/reflux							

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

SURGERIES:

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FAMILY HISTORY:

Age(s)/Gender(s)	Medical problems
Father	
Mother	
Siblings	
Children	

SOCIAL HISTORY:

Are you Married Divorced Widowed Single

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

In what city/state/country were you born? _____

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

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

Neighborhood? Urban / city Suburban Rural / farm

Do you have central air/heat? Yes No Do you have a wood-burning fireplace? Yes No

Carpeting: None Area rugs only Wall to wall

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

Indoor: _____

Outdoor: _____

SUBSPECIALISTS: Have you ever seen any of the following....

Yes	No	Specialty	Name/Practice, Address, Phone Number	Date Last Seen
		Allergy/Immunology		
		Ear, Nose, Throat (ENT)		
		Gastroenterology		
		Rheumatology		
		Hematology		
		Ophthalmology		

Signature of Patient (or representative) Date

Signature of Reviewing Provider Date