Atul N. Shah, MD, FACAAI, FAAAAI
Daniel L. Mayer, MD, FAAAAI
Janet E. Kelske, MS, CPNP, ANP-C, AE-C
Joseph A. Poppa, MS, PA-C
Patricia A. Lombardi, PA-C

Dear Patient,

Welcome to our practice!

In order to facilitate your first visit to our office, attached is our "intake" paperwork so that you may review and complete prior to your visit. For your convenience you can either fax the completed paperwork along with your ***insurance card*** *or you may bring it with you.*

If you have any blood work, hospital records or skin tests, please bring a copy of the results with you.

See the attached list of medications that should be stopped prior to your visit if skin testing is necessary.

If your insurance plan requires you to have a referral to see a specialist, you must coordinate getting that referral from your primary care physician ***prior*** *to your appointment with us.* ***All copayments, by contract with the insurance companies, must be paid at the time of your visit.*** *We reserve the right to charge an additional service charge – currently $10.00 – for any copayment left unpaid on the date of service. For your convenience, we accept cash, check, credit/debit cards. It is your responsibility as the patient/insured, to be aware of the current terms of your insurance coverage****. Self-pay patients****- Payment is expected at the time of service.*

*We confirm all appointments, so we appreciate a call 24 hours prior to your exam if you will need to cancel or reschedule****. Any appointment not canceled within 24 hours will be subject to a $25.00 invoice mailed to your home.***

Divorced/Separated parents of minor patients- The parent who consents to the treatment of a minor child is responsible for the service charges related.

With your cooperation and assistance, you should be able to receive all the benefits offered to you and we will be able to concentrate on caring for medical needs.

I understand the office policy stated above and agree to accept responsibility as described above.

Patient Signature: ____ Date: ____________________
(If minor, parent signature)

Print Patient Name: ____

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Patient Information

Patient's Last Name:____________________ First Name:____________________ MI:____ Date of Birth:__________

Patient SS# :___________________ Sex: M / F Parent /Guardian(If Minor):________________________________

Address:______________________________________ City:______________________ State:______ Zip:________

Home Phone:_____________________ Cell Phone:____________________ Work Phone:_____________________

E-mail Address:____ Marital Status: ___S ___M ___D ___W

Primary Care Physician:________________________ Address:__________________________ Phone:___________

Pharmacy Name, Location, & Phone: ____

Patients Occupation: _________________________________ Employer: ___________________________________

Insurance Information – Primary Medical Insurance

Policy Holder's Name: _________________________ Relationship: _________ DOB: __________ SS#:___________

Insurance Plan Name: _______________________ Policy ID:__________________________ Policy Group:_______

Employer: ___________________ Referral Needed?: ___YES* ___NO Effective Date: ____________ Copay: ______

*As a patient/parent, you understand that if a referral is required, it is your responsibility to obtain a referral and provide our office with that document for the services provided by this practice. You are aware and understand that if a referral is **not** obtained, you will be responsible for the charges of services rendered by our medical practice. ____ Initial of Parent/Patient (if minor)

Secondary Insurance? ___ Yes** ___ No **If yes, please indicate the following

Policy Holder's Name: _________________________ Relationship: _________ DOB: __________ SS#:___________

Insurance Plan Name: _______________________ Policy ID:__________________________ Policy Group:_______

Assignment of Benefits and Release of Information

I authorize my insurance benefits to be paid directly to Atul N. Shah, MD, PC for all the medical services rendered. I understand that I am responsible for any account balance for medical services rendered that my insurance does not cover. I certify that the information I have reported with regard to my insurance is correct and accurate. I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. I will notify you of any changes in the above information. I understand my rights under the HIPAA Privacy Laws and have been given the opportunity to ask questions about this notice and I can request a copy of the Notice of Privacy Practices.

Signature of Patient: ____ Date: ___________________

(Parent if minor)

Patient Name: _________________________________ Age: _______ DOB: ____________ Date: ____________

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Patient Intake

Name: ______________________________________ Age: _____ DOB: ___________ Date: ____________

Sex: M / F   Height: ___________   Weight: ____________   Last Dose of Antihistamine: _________________

Whom may we thank for referring you?: _______________ Primary Care Provider: _______________________

Present Illness (HPI):
Reason for Visit/Current symptoms: ____

Environmental Allergies:
Have you ever been diagnosed with Environmental Allergies? Y / N   If yes, which?: Indoor / Outdoor / Both

Food Allergy:
Do you have Food Allergies?: Y / N   If yes, list foods & reactions: ____________________________________

____

Previous Food Challenges? Y / N   If yes, list food and location: ____________________________________

Previous Oral Immunotherapy? Y / N   If yes, list food and location: ____________________________________

Drug Allergy: Y / N   If yes, specify drug(s) & reaction: ____

Latex Allergy: Y / N   If yes, specify reaction: ____

Stinging Insect Allergy: Y / N   If yes, specify insect(s) & reaction: ____________________________________
Did the reaction go beyond local site of sting? Y / N   If yes, describe: ______________________________

Immunology/Infections:
Do you get recurrent upper/lower respiratory infections (Sinusitis, Bronchitis, Pneumonia, etc.) Y / N
How often are you treated with antibiotics?: _________________ Last dose of antibiotics?: _________________

____

Do not write in this area

NY Food Allergy & Wellness

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Patient Name:______________________________________ DOB:____________ Date:_______________

Asthma:
Have you ever been diagnosed with Asthma or "Reactive Airways" or treated with inhalers/nebulizer? Y / N
Have you ever been treated with oral steroids (Prednisone, Medrol) in the past year?: ________________________
Have you ever needed ER visits or hospitalization for Asthma? Y / N If yes, last visit: ________________________

Eczema:
Have you ever been diagnosed with Atopic Dermatitis (Eczema)? Y / N
Have you ever been diagnosed with Contact Dermatitis? Y / N

Immunizations:
Have you had the Pneumonia vaccine? (Prevnar, Pneumovax): Y / N If yes, when: _______________________
Do you get Flu vaccines? Y / N If yes, last received (Month/Year)?: _______________________
Did you get the COVID-19 Vaccine? Y / N If yes, which: ___________ When: _______ Boosted: _______
Are you up to date with other immunizations? Y / N If no, specify: ____________________________________
Any reactions to vaccines? Y / N If yes, which vaccine and reaction: _______________________________

Current Home Environment:
Type of Heating: Radiator / Baseboard / Forced Hot Air / Wood Burning Stove / Pellet Stove
Air Conditioning? Y / N If yes, what kind: ____
Basement?: Y / N If yes, is it finished?: Y / N Ever flooded?: Y / N Is it damp or musty?: Y / N
History of mold or mildew in your home?: Y / N Carpeting in the bedroom?: Y / N
Pets: Y / N If yes, what kinds?: __________________________ Do they sleep in the bedroom?: Y / N

Social History:
____ Non Smoker
____ Smoker: for how many years?: ______ Cigarettes / Pipe / Vape / Cannabis
____ Former Smoker
Is there any secondary smoke exposure? Y / N
Occupation: ______________________________ Work exposure:___________________________________

Females: Are you pregnant?: Y / N

Past Medical & Surgical History:	**Current Medications, Dose, & Frequency:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

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Patient Name:______________________________________ DOB:__________ Date:_______________

Does any of this apply to you?

Constitutional:

Weight loss	Yes / No
Sudden weight gain	Yes / No
Loss of appetite	Yes / No
Fever	Yes / No
Chills	Yes / No
Night sweats	Yes / No
Fatigue/Tiredness	Yes / No

Eyes:

Blurred vision	Yes / No
Double vision	Yes / No
Swelling	Yes / No
Redness	Yes / No
Itching	Yes / No
Watering	Yes / No

Nose/Sinuses:

Sneezing	Yes / No
Itching	Yes / No
Congestion	Yes / No
Postnasal drainage	Yes / No
Runny nose	Yes / No
Snoring	Yes / No
Nasal polyps	Yes / No
Sleep problems	Yes / No
Sinus headaches	Yes / No
Decreased smell	Yes / No
Nose bleeds	Yes / No
Bad smell	Yes / No
Sinus pressure	Yes / No
Frequent infections	Yes / No

Throat/Mouth:

Sore throat	Yes / No
Post nasal drip	Yes / No
Frequent infections	Yes / No
Difficulty swallowing	Yes / No
Swollen glands	Yes / No
Bad breath	Yes / No

Ears:

Itching	Yes / No
Fluid/Popping	Yes / No
Hearing loss	Yes / No
Ringing	Yes / No
Frequent infections	Yes / No

Cardiovascular:

Fast heart beat	Yes / No
Chest pain	Yes / No
Angina	Yes / No
Murmur	Yes / No
Heart attack	Yes / No
Edema/Swelling	Yes / No

Endocrine:

Thyroid disease	Yes / No
Diabetes	Yes / No

Other: ___________________________

Lungs:

Wheezing	Yes / No
Shortness of breath	Yes / No
Shortness of breath with exertion	Yes / No
Cough	Yes / No
Chest tightness	Yes / No

Gastrointestinal:

Indigestion/Heartburn/GERD	Yes / No
Nausea/Vomiting	Yes / No
Diarrhea	Yes / No
Change in Bowel habits	Yes / No
Cramps/Pain	Yes / No
Bloating	Yes / No
Gas	Yes / No

Urogenital - Kidney & Bladder:

Burning with urination	Yes / No
Increased frequency of urination	Yes / No
Yeast infection	Yes / No
Prostate enlargement	Yes / No

Musculoskeletal

Back pain/ Bone pain	Yes / No
Muscle soreness	Yes / No
Arthritis	Yes / No
Lymes Disease	Yes / No

Emotions/Psych:

Irritability	Yes / No
Depression	Yes / No
Anxiety	Yes / No

Hematological/Lymphatic:

Easy bruising	Yes / No
Bleeding	Yes / No
Swollen glands	Yes / No
Anemia	Yes / No
Cancer	Yes / No

Neurological:

Numbness/Tingling	Yes / No
Migraines/Headaches	Yes / No
Dizziness	Yes / No

Skin:

Rashes/Hives	Yes / No
Eczema	Yes / No
Itching	Yes / No
Skin Infections	Yes / No
Hair loss	Yes / No
Dry skin	Yes / No
Poison Ivy	Yes / No
Psoriasis	Yes / No

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Patient Name:_______________________________________ DOB:__________ Date:_______________

Family Members Medical History:
Asthma: ___Mom ___Dad ___Sibling ___Grandparents ___Children ___Other
Hay Fever: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Food Allergy: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Drug Allergy: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Eczema: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Hives: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Animal Allergy: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Sinus Problems: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Other Illnesses: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other

Anything else we need to know?:
____
____
____
____
____

For Office Use Only: History has been reviewed with this patient: ______________________
Date: ______________________

Do not write in this area

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PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy and medical services.

Please review and agree that:

- We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
- Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the service.
- Not all insurance companies/third party payers pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are personally responsible for Knowing and Understanding their own Insurance Policy, Eligibility and Coverage.
- Patients are responsible for payment of outstanding Deductibles and Coinsurance. Co-payments will be collected at the time of service.
- Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
- Any appointment, including allergy testing, missed or not canceled more than 24 hours in advance will incur a $25.00 charge.
- Returned checks are subject to a $35.00 fee.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.
- I understand that should it become necessary to take legal action to collect any outstanding balance after 180 days of non-payment, there will be an **additional 30% late fee** added to my delinquent balance.

The Patient or Patient's Legal Representative hereby acknowledges that he/she is Eligible for Health Insurance Benefits and Coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the Physician and Practices accordingly.

______________________________ ____________________
Patient Name Date of Birth

______________________________ ____________________
Signature of Patient or Guardian Date

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Notice of Privacy Practices

Center for Asthma & Allergy/ NY Food Allergy & Wellness Center's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the Center for Asthma & Allergy/ NY Food Allergy and Wellness Center's office manager.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

This revised information supersedes any previous version of our privacy practices notifications. Any previous written instructions submitted under our previous policy need to be resubmitted in writing under this revision.

I hereby authorize the following individuals to interact with employees of Center for Asthma & Allergy/ NY Food Allergy and Wellness Center, to receive and provide Protected Health Information regarding me. This listing shall remain in effect until revoked in writing by me. (Please check more than one if needed.)

____ Myself only

____ Parent(s)/Guardian(s) *(if patient is a minor)*:____

____ My Spouse:____

____ My Adult Child(ren):____

____ The Following Friends and/or Family:____

For minor children: I am the custodial parent/guardian of _________________________________ and I may legally receive this information.

I have read and reviewed the Center for Asthma & Allergy and NY Food Allergy & Wellness Center's Notice of Privacy Practices.

PATIENT NAME: ____ DATE OF BIRTH: ______________________

SIGNATURE: ____ DATE: __________________________________

RELATIONSHIP TO PATIENT :__________________________ NAME (GUARDIAN): _______________________________

NY
Food Allergy
& Wellness

Please be aware if you are on any of the following medications.
***You MUST** be off them **5-7 days** prior to any Allergy Testing.*

Prescription Antihistamines

- AlleRx
- Astepro/Astelin (Azelastine) Nose Spray
- Doxepin
- Dymista Nose Spray
- Hydroxyzine (Atarax/Vistaril)
- Karbinal ER (Carbinoxamine)
- Meclizine (Antivert)
- Naldecon
- Patanase (Olopatadine) Nose Spray
- Periactin (Cyproheptadine)
- Phenergan (Promethazine)
- RyClora (Dexchlorpheniramine)
- RyVent (Carbinoxamine)
- Rynatan
- Tussionex
- Tussi-12

PLEASE NOTE: The above list may not be comprehensive. Please double check all over the counter medications you are taking, especially sleep aids, to ensure they do not contain antihistamines. If you are uncertain, please check with us.

Non-Prescription Antihistamines

- Actifed
- Advil Allergy Sinus/ PM/Cold & Flu PM
- Alka-Seltzer Plus Sinus Allergy
- Allerest
- A.R.M. Allergy Relief
- BC Cold Powder Multi Symptom
- Benadryl (Diphenhydramine)
- Cetirizine (Zyrtec, Zyrtec-D, & other brands)
- Chlor-Trimeton (Chlorpheniramine)
- Comtrex Multi-Symptom
- Coricidin
- Dimetane
- Dimetapp
- Drixoral
- Fexofenadine (Allegra, Allegra-D, etc.)
- Loratadine (Claritin, Claritin-D, etc.)
- Motrin Allergy Sinus/PM/Cold & Flu PM
- Midol
- Nyquil
- Pamprin
- Pediacare Night Rest
- Percogesic
- Robitussin Night Time Cold
- Sinarest
- Sudafed Plus
- Tavist
- Triaminic Allergy
- Tylenol Allergy Sinus/PM/Cold & Flu PM

If any OTC meds are for Cold & Sinus, Sleep Aids, or Influenza, please also avoid.

The following Medications you must be off for **7 days** prior to any Allergy Testing

- Levocetirizine (Xyzal)
- Desloratadine (Clarinex)
- Prednisone
- Medrol Dose Pack
- Dexamethasone
- Decadron Elixir
- Orapred
- Prednisolone

****All topical steroid preparations are OK****

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