



ALLERGY & ASTHMA CONSULTANTS, LTD.

Appointment with: _____

Please visit our website: www.allergy-asthmaconsultants.com or www.sneezesandwheezes.com

Welcome to our Practice!

Allergy & Asthma Consultants, LTD., is dedicated to providing diagnosis and treatment of allergies and asthma. Appointment locations are in Gurnee, Highland Park and Libertyville, Illinois. We treat each patient as a partner and make patient education a central component of medical care. Sensitivity and discretion are used in handling all of our patients' concerns.

What you need to bring with to your appointment :

- The completed BLUE enrollment form (*front & back*)...ENCLOSED
- The completed HIPAA release form...ENCLOSED
- Your latest insurance card(s) and applicable copay for "Specialist"
- Physician referral forms, if required by insurance to include allergy testing
- List of any current prescriptions and/or over-the-counter medication, including dose and frequency
- Information about your medical and surgical history
- Recent x-ray reports or relevant medical records

**Your INITIAL APPOINTMENT with TESTING
will be approximately 2 hours long.
Please plan appropriately.**

PLEASE AVOID TAKING ANY ANTI-HISTAMINES AT LEAST 48 HOURS PRIOR TO YOUR APPOINTMENT

Anti-histamines can interfere with allergy testing and therefore, must be avoided for 48 to 72 hours prior to testing. If you take any anti-histamines with-in this period of time, testing may not be performed and an additional appointment may need to be scheduled. Below is a partial list of the more commonly used anti-histamines:

- | | | |
|------------|--------------|---------------------|
| • Allegra | Fexofenadine | Astelin Nasal Spray |
| • Benadryl | Rynatan | |
| • Clarinex | Xyzal | |
| • Claritin | Zyrtec | |

☯ Many over-the-counter medications may also contain anti-histamines. ☯

Appointment Cancellations/Changes

*You will need to contact our office at least **48 hours** prior to your scheduled appointment to make any cancellations or changes to avoid a \$50.00 cancellation fee. If you need to change or cancel your appointment and it is after our regular business hours, you may leave a message on our billing/office management voicemail at (847) 775-1112. Thank you.*

Insurance and Payment Information

Allergy & Asthma Consultants, LTD., is a provider for most major insurance plans and Medicare. Specific questions regarding insurance "coverage and benefits" and referrals should be directed to your employer or insurance company. When requesting coverage and benefits information from your insurance carrier be sure to specifically ask about "allergy benefits" to include allergy testing.

If you have questions regarding our billing practices, which insurance plans we accept or the costs for your testing appointment, please call us at (847) 775-1112. You will be responsible for charges that are not covered by your insurance, at the time of your appointment.

Your insurance company may require a co-payment at the time of your appointment. When necessary, our staff will work with patients to set up a payment plan.

Thank you and we look forward to seeing you at your appointment.

Mark E. Kaplan, M.D.
Stacie A. McMurtry, M.D.

Joel S. Klein, M.D.
Sandra Denman, PA-C

ALLERGY & ASTHMA CONSULTANTS, LTD.

1160 Park Avenue West, Suite 3 South, Highland Park, IL 60035

(847) 432-0200 • Fax (847) 432-0201

1800 Hollister Drive, Suite 106, Libertyville, IL 60048

(847) 549-7711 • Fax (847) 549-1020

36100 North Brookside Drive, Suite 203, Gurnee, IL 60031

(847) 855-1570 • Fax (847) 855-1890

MARK E. KAPLAN, M.D.
STACIE A. McMURTRY, M.D.

JOEL S. KLEIN, M.D.
SANDRA DENMAN, PA-C

* = REQUIRED INFORMATION

(PLEASE PRINT CLEARLY)

Today's Date: _____
(Month/Day/Year)

E-mail: _____

*Patient's Name: _____
* (Last) * (First) (Middle Initial)

*Address: _____
* (Street) * (City) * (State) * (Zip)

*Date of Birth: _____ Age: _____ *Sex: M F Marital Status: S M W D
* (Month/Day/Year)

*Patient Social Security # _____ *Home Phone: (_____) _____ Alt. Phone: (_____) _____
(If 18 years or older)

*Referring Physician: _____
* (Name) * (Address) * (Phone)
~ Referring Physician will receive a consultation letter for your initial visit. If NONE, please write NONE. ~

Referred By: _____
(Name) (Address) (Phone)

Are any members of your family patients of Allergy & Asthma Consultants? Yes No _____
(Name)

Name of Spouse/Parent: _____
(Name) (Address)

*Guarantor for Bill: _____
* (Name) * (Address) * (Social Security #)

Guarantor Employer: _____
(Name) (Address) (Phone)

*Primary Insurance Company: _____ *Group & ID #'s: _____ / _____
* (Carrier Name) * (Group) * (ID #)

*Claims Mailing Address: _____

*Policy Holder Name: _____ *Date of Birth: ____ / ____ / ____

*Secondary Insurance Company: _____ *Group & ID #: _____ / _____
* (Carrier Name) * (Group) * (ID #)

*Claims Mailing Address: _____

*Policy Holder Name: _____ *Date of Birth: ____ / ____ / ____

~ We will require a copy of ALL valid insurance cards to submit your claims. ~

I hereby authorize my insurance benefits to be paid directly to the above-signed physicians, realizing I am responsible to pay any non-covered services. I hereby authorize the release of pertinent medical information to my insurance carrier(s).

X _____ Date
Patient Signature / Guarantor

THANK YOU FOR CHOOSING
ALLERGY & ASTHMA CONSULTANTS, LTD.

PLEASE COMPLETE THE OTHER SIDE
OF THIS DOCUMENT.

ALLERGY SURVEY

Patient's Name: _____

Today's Date: _____

Please complete this allergy information list by **circling** or **underlining** applicable conditions.

Current complaint/symptoms: _____

- EYES:** itching burning tearing swelling redness discharge
- EARS:** itching fullness popping frequent infections draining
Tubes? Yes No If Yes, Date: _____
- NOSE:** itching blocked sneezing running nosebleeds snoring mouth breathing decreased smell
frequents colds polyps (Date of last sinus CT scan: _____)
- THROAT:** sore mucous post-nasal discharge itching
Tonsil & Adenoid Removal? Yes No If Yes, Date: _____
- CHEST:** cough wheeze pain tightness sputum (color _____ amount _____)
shortness of breath: at rest after exertion (Date of last chest x-ray: _____)
- SKIN:** rash eczema hives swelling itching dry
- G-I:** nausea cramping gas diarrhea vomiting weight loss
- HEAD:** headache dizziness lightheaded pressure
- GENERAL:** fatigue fever tension sweats chills insomnia
- PAST HISTORY:** asthma hay fever eczema hives insect-allergy sinus infections pneumonia ear-infections
bronchitis croup
Please list all known food, drug and animal allergies:

- Previous allergy medications?** Yes No
If Yes, Drug names & Dates of use: _____
- Previous treatment by an allergist?** Yes No
If Yes, Dates _____ Dr. _____ Address _____
- Previous allergy injections?** Yes No
If Yes, Dates _____ Dr. _____ Address _____
- Past major illnesses & Dates:** _____
- Past major hospitalizations & Dates:** _____
- Current medications:** Please list all current medications

When do symptoms occur?: spring summer fall winter morning night day indoors outdoors
 exertion weather change emotions old-leaves hay lakeside barns summer home basement attic
 lawn-mowing animals alcohol air conditioning heat dampness/humidity cold
 perfumes chemicals paints hairspray tobacco ozone insecticides newsprint cosmetics latex

Do you smoke? Yes No **Are you exposed to smokers?** Yes No

Do symptoms occur after eating? Yes No If Yes, please list all known or suspected foods:

- FAMILY HISTORY:** Any family members with allergies or asthma? Yes No If Yes, please indicate.
 Father Mother Sister(s) Brother(s) Grandparent(s)
- ENVIRONMENT:** Occupation _____ List work exposures, if any _____
 Recreation & hobby exposure list _____
- Pets/Animals:** Dog(s) Cat(s) Bird(s) Other(s) _____
- Bedroom exposures:** quilts comforters drapes blinds wall hangings books stuffed animals shutters
 air conditioner humidifier air cleaner
 Pillow: Synthetic Feather Carpet in Bedroom? Yes No
 Bedroom heat type: _____ Any stuffed bedroom furniture? Yes No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ALLERGY & ASTHMA CONSULTANTS, LTD.

1160 PARK AVE WEST, STE 3S
HIGHLAND PARK, IL 60035

1800 HOLLISTER DR, STE 106
LIBERTYVILLE, IL 60048

36100 N BROOKSIDE DR, STE 203
GURNEE, IL 60031

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason** _____
