ALLERGY & ASTHMA CENTER OF LAKE NORMAN

Victor A. Agnello, MD
Allergist/Immunologist
Board certified: American Board of Allergy & Immunology

Christina J. Collura, DO
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15815 Brookway Drive, Huntersville, NC, 28078 • Phone: (704) 655-1466 • Fax: (704) 655-1467
311 Williamson Rd. Suite 100, Mooresville, NC, 28117 • Phone: (704) 746-9889 • Fax: (704) 230-0066
www.LakeNormanAllergy.com

Hello and thank you for choosing Allergy & Asthma Center of Lake Norman! We look forward to meeting with you and helping you with your condition.

In order to make your appointment with us efficient and effective we appreciate you filling out the following registration materials ahead of time. In addition, here are a few points to be aware of that will help make your appointment a good experience. Please do not hesitate to contact us with any questions or concerns!

1) If you are being seen for allergies, you may require skin testing. **Therefore, if you are taking an antihistamine, you will need to discontinue it at least 4 days prior to your appointment.** Common antihistamines include:

- **Prescription Antihistamines:** Allegra, Allegra-D, Astelin, Astepro, Atarax (hydroxyzine), Benadryl (diphenhydramine), Bromfed, Cetirizine, Claritin, Claritin-D, Clarinex, Clarinex-D, Chlorpheniramine (CTM), DAllergy, DeconamineSR, Dimetapp, Fexofenadine, Loratadine, Patanase, Phenergan, polyistine, Rynatan, Semprex-D, Tavist, Tavist-D, Xyzal, Zyrtec, Zyrtec-D.

- **Over the Counter:** Alka-Seltzer Plus products, Extra Strength Bayer PM, Benadryl, Cetirizine, Claritin, Comtrex, Contac brand products, Drixoral Cold & Allergy, Excedrin PM, Loratidine, Nyquil, Nytol, Robitussin (Cold Night Time Liquigels & CF), Sominex, Tylenol - Multi-Symptom Formula, Tylenol Cold, Maximum Strength Tylenol Fly Night Time Medicine, Tylenol PM, Tylenol Severe Allergy, Maximum Strength Tylenol Allergy Sinus Night time, Maximum Strength Tylenol Allergy Sinus, Theraflu, Unisom Products, Zyrtec.

2) If you are taking a tricyclic antidepressant (TCA), you cannot be skin tested on your initial visit. Common TCAs include: Amitriptyline, Anafranil (clomipramine), Norpramin (desipramine), Pamelor (nortriptyline), Tofranil (imipramine**). If you are taking these medications for depression, do not discontinue the medication !**

3) A "new patient" appointment can take up to 2 ½ to 3 hours.

4) Please arrive 15 minutes early for your appointment. This will allow us to take care of any unforeseen administrative circumstances.
In addition, if you are more than 10 minutes late, you may be asked to reschedule your appointment. Because a "new patient" appointment can take up to 3 hours, every minute counts! We want to make sure you get all the time you need and deserve.

5) If you are unable to keep your appointment for any reason, please notify us no less than **24 hours in advance**. **Appointments that are missed, cancelled or rescheduled with less than 24 hours notice will be charged a $50 cancellation fee.**

Thank you for your consideration and we look forward to serving you!

Kindly,
The Staff at Allergy & Asthma Center of Lake Norman

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PATIENT DEMOGRAPHIC

PATIENT

PATIENT NAME (First, Middle Initial, Last name)		MARITAL STATUS	DATE OF BIRTH	SEX
STREET ADDRESS	APT/SUITE#	CITY AND STATE	ZIP	
HOME PHONE		DAY PHONE	THIRD PHONE	
PATIENT'S PRIMARY CARE PHYSICIAN		EMPLOYER /SCHOOL NAME	EMPLOYER PHONE	
RACE (CIRCLE) ASIAN BLACK/AFRICAN AMERICAN CAUCASIAN/WHITE HISPANIC/LATINO MULTIRACIAL		LANGUAGE (CIRCLE) ENGLISH SPANISH OTHER	ETHNICITY (CIRCLE) HISPANIC/LATINO NOT HISPANIC/LATINO	
WOULD YOU LIKE TO BE CONTACTED VIA EMAIL REGARDING PRACTICE INFORMATION (INCLUDING CLOSINGS, HOURS, ETC)?		(CIRCLE) YES NO	EMAIL ADDRESS	
PARENT/GUARDIAN		STREET ADDRESS (If different from patient)	CITY/STATE/ZIP	

SUBSCRIBER

INSURED'S NAME (if different from patient)		INSURED'S DATE OF BIRTH	EMPLOYER
RELATIONSHIP TO PATIENT		HOME PHONE	WORK PHONE
STREET ADDRESS	APT/SUITE #	CITY AND STATE	ZIP CODE

AUTHORIZATION FOR PAYMENT AND CONSENT

CONSENT & PAYMENT

I AUTHORIZE PAYMENT OF MEDICIAL BENEFITS TO THIS PRACTICE FOR SERVICES RENDERED. I UNDERSTAND THAT IF I DO NOT HAVE A VALID AUTHORIZATION FROM MY INSURANCE COMPANY TO COVER SERVICES PERFORMED, I WILL BE PERSONALLY RESPONSIBLE FOR THE CHARGES IN FULL, AND I AGREE TO PAY, IN FULL, ANY CO-PAYS, DEDUCTIBLES, OR CO-INSURANCE AMOUNTS THAT MY INSURANCE COMPANY DEEMS MY RESPONSIBILITY, INCLUDING THOSE RESULTING FROM MY FAILURE TO OBTAIN THE NECESSARY REFERRALS AND/OR OTHER AUTHORIZATIONS FROM MY PRIMARY CARE AND/OR REFERRING PHYSICIAN WHEN REQUIRED. I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

I HEREBY AUTHORIZE THIS PRACTICE TO RELEASE INFORMATION TO MY INSURANCE COMPANY, WORKER'S COMPENSATION CARRIER OR MEDICARE. I ALSO AUTHORIZE THIS PRACTICE TO RELEASE MY MEDICAL INFORMATION, INCLUDING PRIVILEGED, SENSITIVE INFORMATION, TO ANY HOSPITAL, PHYSICIAN OR PROVIDER THIS OFFICE AND MY PRIMARY CARE PHYSICIAN MAY REFER ME TO. I HEREBY AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

Signature of Patient or Patient Representative _____ **Date** _____

ALLERGY & ASTHMA CENTER OF LAKE NORMAN

Please fill this form out to the best of your ability and bring it with you to your appointment. Thanks!

NAME (First, Last):_____

CURRENT MEDICATIONS (Pills, inhalers and/or eye drops)

Please list all of the medications you are currently taking
(i.e. Zyrtec, one tablet, once a day):

NAME OF MEDICATION	DOSE	FREQUENCY OF USE

If additional medications need to be listed, please use reverse side of this paper.

PREFERRED PHARMACY	ADDRESS	PHONE NUMBER

Is it okay to leave a detailed message on your answering machine regarding prescriptions or other medical information?_____

MEDICATION ALLERGIES

Please list all of the medications to which you believe you are allergic, as well as a brief description of the reaction (i.e. penicillin, rash):

NAME OF MEDICATION	REACTION

If additional medications need to be listed, please use reverse side of this paper.

PAST MEDICAL HISTORY

Do you currently have any of the following conditions? (please check all that apply):
□ High blood pressure □Diabetes □ Asthma □ Eczema □ Insect allergy
□ Thyroid problems (please circle one if applicable: under-active, over-active)

Please list other medical conditions (i.e. heart disease):

_____ _____
_____ _____
_____ _____

If additional medical conditions need to be listed, please use reverse side of this paper.

PAST SURGICAL HISTORY

Have you ever had any of the following surgeries? (please check all that apply):
□ Sinus surgery □ Tonsils □ Adenoids □ Tubes in ears
Please list other surgeries you have had (i.e. gallbladder removed):

_____ _____
_____ _____
_____ _____

If additional surgeries need to be listed, please use reverse side of this paper.

FAMILY HISTORY

Does anyone else in your immediate family currently have or in the past had any of the following conditions? Please check all that apply:

- Nasal allergies □ Father □ Mother □ Brother □ Sister
- Asthma □ Father □ Mother □ Brother □ Sister
- Eczema (an itchy skin rash) □ Father □ Mother □ Brother □ Sister
- Food allergies □ Father □ Mother □ Brother □ Sister
- Medication allergies □ Father □ Mother □ Brother □ Sister
- Insect sting allergies □ Father □ Mother □ Brother □ Sister
- Recurrent hives □ Father □ Mother □ Brother □ Sister
- Recurrent swelling of the face , tongue, hands and/or feet □ Father □ Mother □ Brother □ Sister

SOCIAL HISTORY

- Do you smoke now, or have you ever smoked on a regular basis?

□Yes □ No

- If you quit smoking, when?

□ Recently □ Several years ago □ Many years ago

*If you do/did smoke, on average, how many packs do/did you smoke per day, and for how many years? #_____ packs per day for ____years

- Does anyone in your current home smoke?

□ No □ Yes, indoor □ Yes, outdoor

- Do you own any pets? □Yes □ No

*If you own a pet(s), please indicate the type(s) (i.e. cat, dog): _____

- If you own a dog, the dog is: □ strictly outdoor □ in and outdoor
  □ strictly indoor □ strictly indoor and sleeps in my bedroom
- If you own a cat, the cat is: □ strictly outdoor □ in and outdoor
  □ strictly indoor □ strictly indoor and sleeps in my bedroom
- How often do you wash the linens on your bed?

□ Several times a week □ Weekly □ Biweekly □ Monthly □ >Month

- What temperature setting do you use to wash your linens?

□ Cold □ Warm □ Hot

- Do you use "dust mite-proof" encasings for your bed's mattress and pillows?

Mattress: □Yes □No Pillows: □Yes □No

- Do you use a humidifier or vaporizer in your bedroom? □Yes □No

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*