PATRICIA E. JONES, M.D.ALLERGY & ASTHMA CENTER, P.C.

232 NE TUDOR ROAD
LEE'S SUMMIT, MO 64086
816-246-2131

Patient_____ Appointment Date: _____Time: _____

Welcome to our practice. Please read the contents of the enclosed packet carefully and complete the enclosed forms prior to your appointment. If you still have questions please call us at 816-246-2131.

ALLERGY TESTING:

You are scheduled to have allergy skin testing done. This test will help determine what substances you may be allergic to. The basic test contains the most common substances causing allergies including tree, grass, and weed pollen, dust mites, cat and dog dander as well as mold to name a few. This test is comprised of a series of skin pricks on your back. You will have to lay flat on an exam table on your stomach for 15 minutes. Please wear a separate top that can be easily removed for this part of the test. After 15 minutes, the nurse will look at your back and grade the reactions. If you are allergic to a substance, it will look and feel like a mosquito bite. Depending on how large that "mosquito bite" is determines if you are allergic to that substance.

INSTRUCTIONS:

1. All antihistamines must be out of your system for this test to be accurate. Most have to be stopped 3 days prior to the appointment. Claritin needs to be stopped 7 days prior to the appointment. **If you are unsure if a medication you are taking is or contains an antihistamine, please ask us or your pharmacist.**
2. Medications for asthma do not need to be discontinued unless instructed by your physician.
3. Wear a separate top that can be easily removed.
4. Plan on being in the office for approximately 1-2 hours. If you are around any "critters" that you would like to have included in your testing (ex. hamsters, horses) please inform the nurse before testing begins.

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The following is a partial list of medications that contain antihistamines. Many oral products for cold and allergy, as well as sleep aids, anti-nausea and antidepressant medications, frequently contain antihistamines. Any product listed below should be stopped 72 hours before you are scheduled for skin testing unless otherwise noted. If you have any questions regarding whether a medication is an antihistamine, please contact your pharmacy.

****NOTICE****
(1) **Discontinue ONLY IF OKAY after checking with PRESCRIBING PHYSICIAN!!
(2) **Discontinue one week before evaluation

Actifed
Alka-Seltzer Plus
Allegra
Allegra-D
Allerest
AllerRx
Alumadrine
Amitriptyline (1,2)**
Antivert
Astelin Nasal Spray
Atrohist
Azelastrine Nose Spray
BC Cold Powder
Bayer P.M.
Benadryl
Bonine
Bromfed
Bufferin AF Nite
Children's Tylenol Allergy D
Children's Tylenol Cold & Flu
Chlorpheniramine
Chlor-Trimeton
Claritin (**2**)**
Claritin D (**2**)**
Cold Control
Compazine
Comtrex
Contac
Coricidin
Cyroheptadine
Desipramine (1,2)**
Dimetapp
Diphenhydramine
Disophrol
Doan's P.M.
Dorcol Cold Formula
Doxepin (1,2)**
Dramamine
Dristin
Drixoral
Dura-Vent/DA
Dymista Nasal Spray
Elavil (**1,2**)**
4-Way Cold Tabs
Histussin
Hycomine
Hydroxyzine
Imipramine (1,2)**
Limbitrol (1,2)**
Loratadine (**2**)
Meclizine
Medi-Flu
Mellaril (1,2)**
Miles Nervine
Naldecon
Nightime Sleep Aid
Nolamine
Nortriptyline (1,2)**
Novahistine
Nyquil
Nytol
Ornade
Patanase Eye Drops
Patanase Nose Spray
Patanol Eye Drops
Pediacure
Periactin
Phenergan
Poly-Histine
Prochlorperazine
Prolixine (1)**
Robitussin Night Time Cold
Rondec
Rynatan
Semprex D
Simply Sleep
Sinequan (1,2)**
Sinutab
Sominex
St. Joseph Night
Stelazine (1)**
Sudafed Cold & Allergy
Surmontil
Tamine
Tavist
Theraflu
Thorazine (1)**
Tofranil (1,2)**
Triaminic
Trifluoperazine
Trilafon
Tripelennamine
Tussagasic
Tussed
Tussi-12
Tussionex
Tylenol Allergy Sinus
Tylenol Cold
Tylenol Cold & Flu
Tylenol Cold Night
Tylenol PM
Unisom
Vicks
Viravan
Vistaril
Vivactil (1,2)**
Zyrtec
Zyrtec D

Plain Sudafed may be taken
Singulair should be stopped 12 hours before testing.

Patient Payment Policy

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusions regarding payment for professional medical services. ***Please sign below that you have read and agree to this policy.***

Payment Policy

Payment for service is due in full at the time of service.

We accept cash, check, Visa and MasterCard.

All fees are based on the type of service provided for your care and related services. Our fees are competitive for this region.

If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account in accordance with the policies outlined above.

For elective or uncovered services, all co-payments and deductibles are due on the date of service. However, for services estimated to cost more than $200, we will accept half of the balance as the minimum payment. Upon request, a short-term payment arrangement can be considered. **All accounts over 30 days will be charged an interest rate of 1.5% per month (18% annually).**

If your account is over 120 days past due, it will be referred to a collection agency. This is a last resort, done reluctantly, and after we have exhausted efforts for voluntary payment.

Referrals

It is your responsibility to bring any required referral for treatment at, or prior to the time of, your visit. If you do not have a referral, your visit will be rescheduled or you may be financially responsible.

Acknowledgement and Authorization

I have read, understand, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility.

_____ _____

Signature Date

_____

Printed Name

PATIENT INFORMATION

Patient Full Name_____

Address_____City_____State_____Zip_____

Home Phone (___) _____Cell Phone (___) _____

Email Address _____

Birthdate_____Age_____Sex_____SSN_____

Employer_____Occupation_____

Marital Status_____Spouses Name_____

How did you hear about our office? _____

Name of Physician referred by_____/Phone #_____

Primary Care Physician_____/ Phone #_____

In case of an emergency notify nearest relative not living with you_____

INSURANCE CARRIER EMPLOYMENT INFORMATION

Insurance Carrier___ _____ Member ID#_____

Person Responsible for Payment_____ DOB _____

Employer _____ Phone (___)_____

Work Address_____State_____Zip_____

Occupation_____SSN_____

Please let us know if the insurance has changed from your last visit to update our records. This ensures timely payment for your visit.

I hereby authorize Patricia E. Jones, M.D., Allergy & Asthma Center and it's physicians to treat me/my child. I authorize payment of my insurance benefits to be made to Patricia E. Jones, M.D., Allergy & Asthma Center for any services furnished to me by the physicians in that group. I understand that I am financially responsible for all charges whether paid by insurance or not. (This excludes patients covered by insurance companies with which we have a contract). Should my account become delinquent, I understand that I may be responsible for additional charges if this account is referred to an attorney. I understand that the privacy practices are posted in the office, and a copy is available to me if I request one. I also authorize Patricia E. Jones, M.D., Allergy & Asthma Center to release medical information to insurance companies in order for the insurance companies to determine payment for services rendered to me. This shall serve as a lifetime authorization.

XXXX

SIGNATURE

Allergy & Asthma Center
Patricia E. Jones, M.D.
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Allergy Immunology New Patient Questionnaire

Your answers on this form will help your doctor get an accurate history of your medical concerns and conditions in order to better help you. Please bring this completed form to your first appointment.

Patient Name:_____ Accompanied By:_____ Date:_____

Who referred you to our clinic? _____ Primary Care Physician:_____

Please describe the reasons for your allergy visit and what you hope to accomplish:

_____

_____

1. Have you ever had any of the following problems?

Yes	No	Problems	Age of Onset	Comments
		Cough		
		Nasal Allergies (Runny, stuffy, itchy nose, sneezing)		
		Sinus Problems		
		Asthma		
		Any Other Breathing Problems		
		Eczema or Other Rashes		
		Latex Allergy		
		Vaccine Allergy		
		Stinging Insect Allergy		
		Frequent Infections		

2. Have you ever had the following symptoms? If not, leave blank.

Symptoms	Severity		
	Mild	Moderate	Severe
Sneezing			
Itchy nose			
Runny nose			
Dripping sensation at the back of the throat			
Cough			
Throat clearing			
Nasal congestion			
Ear pain/popping/fullness			
Red eyes			
Itchy eyes			
Watery eyes			
Headaches			
Sinus pain or pressure			
Discolored nasal drainage			
Decreased sense of smell			
Snoring			
Mouth breathing			
Nighttime pauses in breathing			
Waking up at night choking or gasping for air			

3. If you have asthma, have you ever been:

Hospitalized for asthma? Y N

Treated in the emergency room for asthma? Y N

Treated with oral steroids for an asthma attack? Y N If yes, how many times? _____

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How many asthma attacks do you estimate you have had in your lifetime? _____ In the last year? _____

4. Over the last four weeks, have you had problems with:

	Never	Once or twice a week	3-6 times a week	Once a day	More than once a day
Cough					
Wheeze					
Chest Tightness					
Shortness of breath					
Use of rescue inhalers (e.g. Albuterol)					

Have you had problems with waking up at night because of trouble breathing? (Circle one)

Not at all 1-2 times per month 3-4 times per month More than once a week Every night

5. Please circle any factors that seem to trigger your allergy or asthma symptoms.

Pollens	Smoke	Exposures at work (e.g. chemicals, paints, flour): Specify
Raking Leaves	Air Conditioning	
Dust	Forced Air Heat	
Mold/Mildew	Strong Odors	
Animals: Specify	Pregnancy	
	Menstruation	
Exercise	Alcohol	
Cold Air	Stress	
Infections		

6. Are the allergy symptoms present (circle one): Throughout the year Only during certain seasons

What seasons or months are they worse?_____

7. Have you missed time from school or work because of your allergies or asthma?_____ If so, how many? _____

8. Have you ever had allergy testing? ☐ Yes ☐ No If yes, date(s):_____ Physician's Name:_____

9. Please list below any medications you have tried for your

Medication	Dose	Frequency	How long did you try it?	Effectiveness			Side Effects
				Helped a little bit	Helped a moderate amount	Completely relieved symptoms	

10. Have you ever received allergy injections? ☐ Yes ☐ No **Were they of any benefit?** ☐ Yes ☐No

11. Have you had a chest X-ray? When? _____ **What were the results?** _____

12. Have you had a sinus X-ray? When? _____ **What were the results?** _____

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13. Have you had a pneumonia vaccine? ☐Yes ☐ No **When?** _____

14. Date of last influenza vaccine? _____

15. Review of Systems: Please circle any of the symptoms below that you are currently experiencing. Check box if you are not having symptoms.

None						
☐	Constitutional:	Fever	Chills	Sweats	Weakness	Fatigue
☐	Eyes:	Dry eyes	Recent visual problem		Swelling	
☐	Ears/Nose:	Hearing Loss	Pain	Nasal congestion	Sore throat	
☐	Respiratory:	Shortness of breath	Cough	Wheezing	Sleep apnea	
☐	Cardiovascular:	Chest pain	Skipped Heartbeat	Racing heart	Swelling in legs	
☐	GI:	Nausea Stomach pain	Vomiting	Diarrhea	Constipation	Heartburn
☐	Hema/Lymph:	Easy bruising	Easy bleeding	Swollen lymph glands		
☐	Endocrine:	Excessive thirst	Excessive urination	Cold intolerance	Heat intolerance	
☐	Immunologic:	Recurrent fevers	Recurrent infections	Malaise		
☐	Musculoskeletal:	Back pain	Neck pain	Joint pain	Muscle pain	
☐	Skin/hair:	Rash	Itching	Dry skin		
☐	Neurologic:	Confusion	Dizziness	Headache		
☐	Psychiatric:	Anxiety	Depression	Stress		

Past Medical:

16. Other Illnesses: List any illnesses or conditions you have ever had.

Condition/Illness	Age	Currently being treated?	Current Physician
_____	___	☐Yes ☐No	_____
_____	___	☐Yes ☐No	_____
_____	___	☐Yes ☐No	_____
_____	___	☐Yes ☐No	_____
_____	___	☐Yes ☐No	_____

17. Females only (☐ Not applicable)

a. Last known menstrual cycle ___/___/___

b. Chance of pregnancy? ☐ Yes ☐No

18. Immunizations

a. Are your immunizations current? ☐Yes ☐No

b. Do you receive annual flu vaccines? ☐Yes ☐No

19. Surgeries/Injuries List any surgeries or injuries since birth.

a. Surgery/Injury	Date/Age	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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20. Hospital/ER Visits List any hospital or ER visits within the last 5 years

a. Reason _____ Date _____ Complications? _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

21. Past transfusions

a. **Have you ever had blood or blood product transfusions?** ☐ Yes ☐No

22. Family history Do any members of your biologically related family have a history of the following?

	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Daughter	Son
Allergic Rhinitis										
Asthma										
Cystic Fibrosis										
Eczema										
GERD										
Migraine										
Sinus Disorder										
Thyroid Disease										
Other										

23. Social and Environmental History

What is your occupation? _____ Ethnic Background? _____

What are your hobbies? _____

Do you have pets? ☐ Yes ☐No List number and kind (dog, cat, birds, horse, etc) _____

_____

Have you ever smoked? ☐ Yes ☐No If yes, how many years? ____ Do you presently spoke? ☐ Yes ☐No

When did you stop? _____ Average cigarettes per day at highest point? _____

If you still smoke, do you think you could stop? ☐ Yes ☐No Does anyone smoke in or out of your house? ☐ Yes ☐No

How old is your home? _____ Has there been any water leakage or damage in your home? ☐ Yes ☐No

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Current Medications

Medication Name	Dose	Frequency

(If not enough space has been provided please continue the list on a separate sheet of paper and attach it to the back.)

Do you have any known drug allergies or intolerance to medications? ☐ **Yes** ☐ **No**

Medication Allergies

Medication Name	Type of Reaction	Date/Age

Food Allergies

Food	Type of Reaction	Date/Age

Preferred Pharmacy

Pharmacy Name:_____ Phone Number:_____

Pharmacy Address:
Street: _____

City:_____ State:_____ Zip Code:_____

Prescription Type: ☐ 90 Day Mail in ☐ Local ☐ Mail and Local

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Dear Patient,

In order to protect your confidentiality and to comply with government regulations (HIPAA), Dr. Patricia Jones is required to obtain authorization from you in order to release messages and/or provide information regarding your care with any person(s) other than yourself.

RELEASE OF MEDICAL INFORMATION:
The physician and staff at Dr. Patricia Jones Allergy and Asthma Center may discuss my medical information and/or care with the following: **(Please check all that apply.)**

† Name _____Relationship _____

† Name _____Relationship _____

† Name _____Relationship _____

† Name _____Relationship _____

MESSAGES:
I give my consent to Dr. Patricia Jones and staff of Dr. Jones office to leave or discuss treatment, lab, radiology results or other information regarding my care as follows: **(Please check all that apply.)**

† On answering machine or voice mail at **home.** # _____

† On answering machine or voice mail on **cell phone.** # _____

† On answering machine or voice mail at **work.** # _____

† I do not consent to messages being left at home, work, or with any other person.

Patient's Name: _____ **Date of Birth:** _____
(Please print)

Patient's Signature: _____ **Today's Date:** _____
(If a minor Parent or Guardian)