ALLERGY EXPERTS
NEW YORK ALLERGY & ASTHMA

PATIENT REGISTRATION FORM

Patient's Name: _____ Age: _____ DOB: _____ Sex: M F

Maritial Status: _____ SS#: _____ Address: _____

City, State, ZIP: _____ Email: _____

Home#: _____ Work#: _____ Cell#: _____

Employer: _____ Occupation: _____ Employer Address: _____

Primary Insurance: _____ Phone#: _____

Insurance Address: _____

ID#: _____ Group#: _____

Name of Insured: _____ Employer: _____

Relationship: _____ Insured's Social Security: _____

Date of Birth: _____ Refferal Required: Y N Copay $: _____

Secondary Insurance: _____ Phone#: _____

Insurance Address: _____

ID#: _____ Group#: _____

Name of Insured: _____ Employer: _____

Relationship: _____ Insured's Social Security: _____

Date of Birth: _____ Refferal Required: Y N Copay $: _____

Referring Physician/Person: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Pharmacy: _____ Phone#: _____

I hereby authorize Allergy Experts-New York Allergy and Asthma PLLC, to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named Physician of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney/collection agency for collection, that I will be responsible for collection fees, attorney's fees, and court cost and interest.

Signature: _____ Date: _____

Patient/Guardian Signature

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may used or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign you name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: :Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker’s Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicate in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care

or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physicians believes it is in your best interest to permit use and disclose of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Shelisha Ramnarine, our HIPAA compliance officer. We will not retaliate against you for filing a complaint.

This notice was published and become effective on/or before April 14, 2003.

Acknowledgement of Receipt of Notice of
PRIVACY PRACTICES

I have been presented with a copy of the Notice Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I agree that New York Allergy & Asthma may request and use my prescription medication history from other healthcare providers or third- party pharmacy benefits payors for treatment purposes.

Signature below is only acknowledgement that you have received this Notice of our Private Practices:

Patient's Name: _____ Signature: _____

Relationship (if not patient): _____ Date: _____

INTERNAL USE ONLY

If patient/patient's representive refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date): _____ Time: _____

By (name): _____ Time: _____

Signature: _____

CANCELLATION POLICY

MISSED APPOINTMENT

Please note that the office visit scheduled with Dr Sebastian Lighvani at New York Allergy And Asthma must be cancelled at least twenty four hours prior to the appointment date to avoid a cancellation fee. You will be Billed $150.00 for missed appointment.

I _____ am aware that I am required to notify New York Allergy And Asthma during office hours (Monday- Friday between 9:00a.m.-5:00p.m.) of cancellations within at least twenty four hours of my scheduled appointment.

Patient's Name: _____ Date of Birth: _____

Date: _____ Signature: _____

INITIAL ALLERGY EVALUATION FORM

Patient's Name: _____ Age: _____ DOB: _____ Date: _____

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

PLEASE LIST ALL THE REASON(S) FOR YOUR VISIT:

NASAL & EYE ALLERGY HISTORY:

Answer the sections that apply to your condition(s)

DO NOT WRITE IN THIS AREA

Mark the following if they apply to you:

- ☐ Sneezing
- ☐ Itchy nose
- ☐ Itchy eyes
- ☐ Nasal congestion
- ☐ Post nasal drip
- ☐ Cough
- ☐ Loss of smell
- ☐ Headache
- ☐ Ear problems
- ☐ Facial Pain
- ☐ Runny Nose (clear, yellow or green)
- ☐ Watery eyes

Other: _____

Approximate Date of Onset of your Nasal symptoms:

When are your symptoms present? _____

☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ All Year

Suspected triggers of your symptoms:

- ☐ Trees
- ☐ Grasses
- ☐ Weeds
- ☐ Mold
- ☐ Dust
- ☐ Cat
- ☐ Dog
- ☐ Latex
- ☐ Foods
- ☐ Aspirin/Advil/Motrin
- ☐ Colds
- ☐ Cold air
- ☐ Smoke
- ☐ Odors
- ☐ Fumes/Perfume
- ☐ Beer
- ☐ Wine

Other: _____

What Medications have you tried and their effects:

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever been tested for Allergies? ☐ Yes ☐ No

Date: _____ Result: _____

Have you ever been on Allergy Shots? ☐ Yes ☐ No

Date: _____ Effect: _____

DO NOT WRITE IN THIS AREA

SINUSITIS HISTORY:

Number of Sinus Infections last year treated with Antibiotics:

- ☐ None
- ☐ 1-2
- ☐ 3-4
- ☐ 4-5
- ☐ >5

List Antibiotics Most Commonly Used: _____

Duration of a Typical Sinus Infection:

- ☐ None
- ☐ 7-10 days
- ☐ 14-21 days
- ☐ 3-6 weeks
- Other: _____

Do you have a prior history of SINUS SURGERY or NASAL POLYPS?

☐ Yes ☐ No

ASTHMA, WHEEZING, CHRONIC COUGH, BRONCHITIS:

Description of Symptoms:

- ☐ Wheeze
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Chest tightness
- ☐ Throat tightness
- ☐ Phlegm
- ☐ Worse at night
- ☐ Worse during day
- ☐ Shortness of breath w/Activity
- Other: _____

Date of Onset of symptoms: _____

Frequency of Symptoms:

- ☐ None
- ☐ <2 days/week
- ☐ 3-6 days/week
- ☐ Everyday
- ☐ Continuously

Do your asthma symptoms wake you up at night?

- ☐ None
- ☐ <2/month
- ☐ >2/month
- ☐ >1/week
- ☐ Frequent

Emergency Room Visits or Hospitalizations for Asthma:

- ☐ None
- ☐ 1-2
- ☐ 3-4
- ☐ >5
- ☐ Within last year

Please Circle all of the following that CAUSE and/or WORSEN your respiratory symptoms:

- ☐ Viral Infections
- ☐ Exercise
- ☐ Pollens
- ☐ Dust
- ☐ Mold
- ☐ Animals
- ☐ Latex
- ☐ Medications
- ☐ Emotions
- ☐ Smoke
- ☐ Menses
- ☐ Cold Air
- ☐ Sinusitis
- ☐ Foods: (specify)
- ☐ Acid Reflux

Please list ALL medications taken for this, how often and effects:

_____ _____

_____ _____

DO NOT WRITE IN THIS AREA

Please indicate how often you use your RESCUE inhaler: (e.g. Albuterol)

☐ None ☐ 1-2 x /week Daily#: _____
☐ <1/week ☐ 3-6 x /week

Have you been prescribed any STEROIDS for Asthma Condition?

☐ None ☐ 3-5 times ☐ Within last year
☐ 1-2 times ☐ >5 times

HEARTBURN, INDIGESTION or ACID REFLUX:

Please mark if apply to you:

☐ Throat Cearing ☐ Choking ☐ Difficulty Swallowing
☐ Hoarseness ☐ Burping ☐ Acid in the mouth
☐ Cough ☐ Indigestion

How many carbonated, caffeinated, or alcoholic drinks/day? _____ Coffee/Tea/Soda/Alcohol

How late in the evening do you eat? _____

Do any of your symptoms worsen after you eating? ☐ Yes ☐ No

SKIN CONDITIONS:

(Describe Rash/Date of Onset/Location/Triggers)

☐ Eczema ☐ Rash ☐ None
☐ Hives ☐ Other: _____
☐ Swelling

How often do you have this problem?

☐ Less than weekly ☐ 1-2 days per week ☐ 3-6 days per week ☐ daily

Known or Suspected cause of the rash: _____

Treatments tried so far and response: _____

Are you taking an ACE-Inhibitor? ☐ Yes ☐ No

FOOD ALLERGY:

(Describe reactions/Food/Amount/Time course/Treatment) ☐ None

Have you ever received or been prescribed an EPINEPHRINE Injection (EPIPEN): ☐ Yes ☐ No

DRUG ALLERGY:

(Describe Reactions) ☐ None

INSECT ALLERGY:

(Describe Reactions) ☐ None

LATEX/RUBBER ALLERGY:

(Describe Reactions) ☐ None

DO NOT WRITE IN THIS AREA

INFECTION/IMMUNIZATION HISTORY:

Childhood immunizations up-to-date? ☐ Yes ☐ No

Annual flu vaccine? ☐ Yes ☐ No Pneumovax? ☐ Yes ☐ No

TB skin test? ☐ Yes ☐ No

Please mark all conditions that you have experienced:

- ☐ Frequent Sinus Infections
- ☐ Frequent Throat Infections
- ☐ Fequent Ear Infections
- ☐ Frequent Bronchitis
- ☐ Immune disorder
- ☐ Frequent Pneumonia
- ☐ Family History of Immunodeficiency
- ☐ Abnormal Chest X-Ray
- ☐ Severe Infections: _____

PAST MEDICAL HISTORY:

Please mark all medical conditions that you have experienced:

- ☐ High Blood Pressure
- ☐ Gastrointestinal
- ☐ Heart Disease
- ☐ Seizures
- ☐ Migraine
- ☐ Cancer
- ☐ Hepatitis
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Severe Infections
- ☐ Positive PPD

Other: _____

LIST ALL HOSPITALIAZTIONS/SURGERIES: ☐ None

_____ _____ _____

List all MEDICATIONS & SUPPLEMENTS you are taking: ☐ None

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

FAMILY HISTORY

	Age	Asthma	Hayfever	Sinusitis	Eczema	Food Allergy	Other	Deceased (cause)
Father		☐	☐	☐	☐	☐		
Mother		☐	☐	☐	☐	☐		
Brothers		☐	☐	☐	☐	☐		
Sisters		☐	☐	☐	☐	☐		
Children		☐	☐	☐	☐	☐		

DO NOT WRITE IN THIS AREA

ENVIRONMENTAL HISTORY:

How long have you lived in this region of the country? _____

List Previous Residences: _____

List ALL ANIMALS at home & Access to Bedroom: _____

Note ALL SMOKERS at home: _____

Type of home:

☐ Apartment ☐ House ☐ Dormitory

Other: _____ Age of home: _____

Bedroom:

Bed	☐ Mattress	☐ Waterbed	Age: _____
Pillows	☐ Synthetic	☐ Feather	☐ Allergy cover
Comforter	☐ Synthetic	☐ Feather	☐ Allergy Cover
Flooring	☐ Carpet	☐ Wood	☐ Area Rug
Other	☐ Stuffed Toys	☐ Pets	

AC:

☐ Central ☐ Window ☐ Window ☐ Dehumidifier

Heat:

☐ Forced hot air ☐ Electric ☐ Gas ☐ Wood burning stove

Other: _____

Basement:

☐ Synthetic ☐ Carpet ☐ Stuffed Toys

OCCUPATONAL HISTORY:

Current/ Previous Occupation(s): _____

Exposures at work:

☐ Chemicals ☐ Fumes ☐ Latex

Other: _____

Are your symptoms worst at work? ☐ Yes ☐ No

Missed School or work because of your condition? _____

DO NOT WRITE IN THIS AREA

SOCIAL HISTORY:

Smoker? ☐ Yes ☐ No Pack per day: _____ for _____ years

Quit? ☐ Yes ☐ No Date: _____

Marijuana ☐ Yes ☐ No

Illicit Drugs ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No Quantity per week: _____

Marital Status: _____

_____

REVIEW OF SYSTEMS:

General Health Problems: _____ ☐ None

Eye Symptoms: _____ ☐ None

Heart Symptoms: _____ ☐ None

Gastrointestinal Symptoms: _____ ☐ None

Kidney/Bladder Symptoms: _____ ☐ None

Skin Symptoms: _____ ☐ None

Blood Symptoms: _____ ☐ None

Neurological Symptoms: _____ ☐ None

Psychiatric Symptoms: _____ ☐ None

Muscle/Joints Symptoms: _____ ☐ None

TO BE COMPLETED BY PHYSICIAN

Date	MD
_____	_____
_____	_____
_____	_____
_____	_____

☐ HISTORY AND EXAMINATION ☐ DETAILED ☐ COMPREHENSIVE

☐ COMPLEXITY OF MEDICAL DECISION MAKING ☐ COMPREHENSIVE ☐ HIGH

MEANINGFUL USE DEMOGRAPHIC

Race Choices

- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian
- ☐ Unknown
- ☐ White

Ethnicity Choices

- ☐ Hispanic Origin
- ☐ Non-Hispanic Origin
- ☐ Unknown

LANGUAGE CHOICES

- ☐ Arabic
- ☐ Armenian
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ French Creole
- ☐ German
- ☐ Greek
- ☐ Gujarati
- ☐ Hebrew
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Unknown
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish