OCEAN ALLERGY
ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

WELCOME LETTER

WELCOME TO OUR PRACTICE!

WE ARE LOOKING FORWARD TO MEETING YOU AND ASSISTING WITH YOUR MEDICAL CARE. IN AN EFFORT TO ENSURE AN OPTIMAL APPOINTMENT EXPERIENCE, PLEASE ARRIVE 20 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

PLEASE BEGIN BY GOING TO OUR WEBSITE AT **OCEANALLERGY.COM** AND PRINT AND COMPLETE YOUR REGISTRATION FORMS. IN ADDITION TO YOUR PATIENT REGISTRATION FORMS, PLEASE BE SURE TO BRING WITH YOU:

- PHOTO ID
- INSURANCE CARDS
- LIST OF ALL CURRENT MEDICATIONS
- REFERRAL IF REQUIRED
- LABORATORY/X-RAY RESULTS (WRITTEN REPORTS ONLY)
- PERTINENT MEDICAL RECORDS
- CO-PAY IF APPLICABLE

YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED IF THE ABOVE DOCUMENTATION IS NOT PRESENTED AT THE TIME OF CHECK-IN.

IN THE EVENT THAT ALLERGY TESTING IS PERFORMED, PLEASE REFER TO THE GUIDELINES BELOW:

DO NOT APPLY ANY MOISTURIZERS TO YOUR SKIN ON THE DAY OF YOUR APPOINTMENT.

PLEASE STOP ANTIHISTAMINES 7 DAYS PRIOR TO YOUR VISIT. These include but are not limited to:

BENADRYL (DIPHENHYDRAMINE)	ZYRTEC	XYZAL (LEVOCETIRIZINE)	ASTEPRO (ASTELIN)
CLARITIN (LORATADINE)	CLARINEX (DESLORATADINE)	ALLEGRA (FEXOFENADINE)	ALLERGY EYE DROPS
ZANTAC (RANITIDINE)	ATARAX (HYDROXYZINE	DOXEPIN/ ELAVIL	PEPCID (FAMOTIDINE)
PATADAY / PAZEO	CHLORPHENIRAMINE	PATANOL	CHLOR-TRIMETON
PATANASE			

YOU MAY CONTINUE ALL OTHER MEDICATIONS INCLUDING ANY ASTHMA INHALERS. IF YOU HAVE ANY QUESTIONS REGARDING STOPPING ANY MEDICATIONS, PLEASE CALL OUR OFFICE AND SPEAK WITH A MEMBER OF OUR STAFF.

ALL APPOINTMENTS MUST BE **CONFIRMED OR CANCELLED 24 HOURS** PRIOR TO THE SCHEDULED VISIT. NO SHOW AND APPOINTMENTS THAT HAVE NOT BEEN CANCELLED ARE SUBJECT TO MISSED APPOINTMENT FEES WHICH ARE DUE AT TIME OF SERVICE.

THANK YOU FOR TAKING THE TIME TO PREPARE FOR YOUR VISIT TO OUR OFFICE. WE LOOK FORWARD TO SEEING YOU!

APPOINTMENT DATE: _____ TIME: _____

WITH DR. / NP _____

BRICK OFFICE	1673 ROUTE 88 WEST BRICK NJ 08724	T- (732) 458- 2000	F- (732) 458- 4523
WALL OFFICE	1540 ROUTE 138 WEST BLDG 1 STE 103 WALL NJ 07719	T- (732) 681-8700	F- (732) 749-3737

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PATIENT DEMOGRAPHICS FORM

Today's Date_____

Patient Name _____ **Marital Status** ___S___M___W___D

DOB_____/_____/_____ **Age** _____ **Male** ___ **Female** ___ **SSN**: _____

Address _____ **Home Phone** _____

City: _____ **Cell Phone** _____

State _____ **Zip Code** _____ **Work Phone** _____

Email: _____

Primary Care Physician: _____ **Telephone #**_____

Race _____ **Ethnicity**_____ **Preferred Language** _____

Responsible Party if Minor _____**Relationship** _____

Address: _____ **City**_____ **State** _____ **Zip Code**_____

Employer: _____ **Occupation**_____ **Tele#**_____

INSURANCE INFORMATION PLEASE PRESENT ALL INSURANCE CARDS

Primary Ins Co._____ **ID#:**_____ **Group#**_____

Subscriber: _____ **SSN**: _____ **DOB**: _____

Relationship to patient: _____

Secondary Ins Co. _____ **ID#** _____ **Group#** _____

Subscriber: _____ **SSN**: _____ **DOB**: _____

Relationship to Patient: _____

EMERGENCY CONTACT

Name: _____ **Telephone**: _____ **Relationship**: _____

I certify that the information I have given today is to the best of my ability as complete and accurate as possible. I will notify the doctor/staff of any changes or additions at subsequent visits.

RELEASE OF INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS AND FINANCIAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

PRINT NAME_____ **SIGNATURE**_____ **DATE** _____

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INITIAL VISIT QUESTIONNAIRE

Please answer all questions in their entirety. This is part of the medical history and is therefore confidential.

Name _____ Gender male/ female Birthdate _____

Referring Physician: _____ Tele # _____

Please list the major reason(s) for your visit: _____

PHARMACY NAME AND TELEPHONE NUMBER_____

If appropriate, please circle the months the symptoms are most prominent:

Jan Feb March April May June July Aug Sept Oct Nov Dec

PREVIOUS ALLERGY EVALUATION (indicate when and where) _____

TRIGGERS: PLEASE CIRCLE ALL THAT APPLY

DUST	FEATHERS	DOG	CAT	MOLD	FOODS	DRUGS	HUMIDITY	COLD TEMPS
STRONG ODORS	FRAGRANCE	TEMPERATURE CHANGES	WORKPLACE	HOME	FALL	SPRING		

PLEASE LIST ALL OF YOUR MEDICAL CONDITIONS PLEASE LIST ALL OF YOUR SURGERIES

FAMILY HISTORY: (please indicate which family members have allergy/immunology diseases

	MOTHER	FATHER	SIBLINGS	OTHER FAMILY MEMBERS
ENVIRONMENTAL ALLERGIES				
FOOD ALLERGIES				
ECZEMA				
ASTHMA				
RECURRENT INFECTIONS				
IMMUNE DEFICIENCY				

PLEASE LIST ALL DRUG ALLERGIES: _____ _____ _____ _____ _____

PLEASE LIST ALL FOOD ALLERGIES: _____ _____ _____ _____ _____

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE TAKING WITH DOSAGE AND FREQUENCY

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

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INITIAL VISIT QUESTIONNAIRE

SOCIAL HISTORY: (CIRCLE ALL THAT APPLY) **NAME: _____**

SMOKING STATUS:	CURRENT SMOKER	FORMER SMOKER	NEVER SMOKER

HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN A LIFETIME?	YES	NO
DO YOU USE A SMOKELESS TOBACCO PRODUCT?	YES	NO
ARE YOU AT RISK FOR SECOND HAND SMOKE?	YES	NO

CURRENT OCCUPATION _____FORMER OCCUPATION _____

HAVE YOU HAD ANY OCCUPATION WITH ALLERGIC OR TOXIC EXPOSURE? _____

IF YES WHEN AND WHAT WAS THE EXPOSURE? _____

ENVIRONMENTAL HISTORY: (FOR PATIENTS WITH ASTHMA, NASAL ALLERGIES, OR SINUS DISEASE CIRCLE WHERE APPROPRIATE)

HOME:	HOUSE	APARTMENT	CONDO	MOLD/WATER DAMAGE
RUGS:	WALL TO WALL	AREA		
HEATING SYSTEM:	RADIATOR	HOT WATER BASEBOARD	FORCED HOT AIR	OTHER
BEDROOM:	SHARED	SINGLE		
ALLERGY PROOF COVER	PILLOWS	MATTRESS	BOX SPRING	
PETS:	CATS	DOG	OTHER	

REVIEW OF SYSTEMS: (please circle all that apply)

CONSTITUTIONAL:	LOSS OF APPETITE	FEVER	NIGHT SWEATS	RECENT FATIGUE	SYSTEMIC ILLNESS	RECENT WEIGHT GAIN/LOSS
HEAD:	HEAD TRAUMA	HEADACHE				
EYES:	BLURRED VISION	VISUAL CHANGES	ITCHING/TEARING	REDNESS	LIGHT SENSITIVITY	PAIN
ENT:	HEARING LOSS	BLOODY NOSE	SINUS CONGESTION	DIFFICULTY SWALLOWING		
RESIRATORY:	COUGHING BLOOD	WHEEZING	COUGHING	SPUTUM PRODUCTION	SHORTNESS OF BREATH	
CARDIOVASCULAR:	CHEST PAIN	RAPID OR IRREGULAR HEARTBEAT	DIFFICULTY BREATHING WHEN LYING DOWN	SHORTNESS OF BREATH AWAKENING FROM SLEEP	LOWER EXTREMITY SWELLING	
GASTROINTESTINAL:	NAUSEA	VOMITING	ABDOMINAL PAIN	CHANGE IN BOWEL HABITS		
SKIN:	RASHES	SKIN ULCERS	HIVES	ITCHINESS		
NEUROLOGICAL:	DIZZINESS	HEADACHE	SYNCOPE	WEAKNESS		
ENDOCRINE:	HYPO-GLYCEMIA	EXCESSIVE THIRST	EXCESSIVE URINATION			
HEMATOLOGIC/LYMPHATIC:	EASY BRUISING	BLEEDING	CLOTTING DISORDER	CALF PAIN		
ALLERGY/IMMUNOLOGY:	SEASONAL ALLERGIES	FOOD ALLERGIES	DRUG ALLERGIES			
GENERALIZED PAIN:	YES	NO				

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FINANCIAL POLICY

We are pleased you have chosen us as your providers. We appreciate your trust and our goal is to provide you and your family the highest quality of medical care.

Our practice is contracted with numerous insurance carriers. Policies can change and subscribers need to know their own plans benefits and financial responsibilities, such as deductibles, co-pays, and co-insurances.

Your insurance may require a **referral** from your **Primary Care Physician** to be seen by a specialist. This must be obtained at least 72 hours prior to your visit**. It is the patient responsibility to know if a referral is required by your insurance** to see a **specialist. If you are seen without a required referral, you will be responsible for any balances incurred if your insurance company states so**. **If a referral cannot be obtained by your appointment date you will need to reschedule.**

Should you choose to be seen in our practice and we do not participate with your insurance plan, you are responsible for the full payment of you bill at the time of service. We will provide you with an itemized receipt so you may file for reimbursement.

Dependent Minors of Divorced Parents: We expect payment from the parent/guardian who accompanies the child to our office. We will not bill a non-custodial parent, even though this may be part of the divorce agreement. We will be pleased to provide a paid receipt for services rendered.

We reserve the right to charge for missed appointments or any appointments **not cancelled 24 hours prior to the scheduled appointment.**

Past due balances are expected to be paid in full before future appointments are made. You agree to reimburse the fees of any collection agency which may be based on a percentage at a maximum of 50% of the debt, and all costs and expenses including reasonable attorney fees we incur in such collection efforts.

Our office accepts **Cash, Check, Visa, Mastercard, and Discover** for your convenience.

I have read and understand the financial policy stated above and authorize payment of any insurance benefits for unpaid services to Ocean Allergy and understand that I am responsible for any balances or unpaid insurance claims and other fees as described. I authorize the release by Ocean Allergy of my medical information that is necessary to evaluate and pay my medical insurance claims.

Print Patient Name _____

Patient Signature_____ Date: _____

Patient Representative's Name _____ Relationship to patient_____

Patient Representative Signature _____

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HIPAA RELEASE FORM

NAME: _____ DATE OF BIRTH ____/____/_____

RELEASE OF INFORMATION

_____I authorize the release of information including claims information, diagnosis, and examination records rendered to me.

The information may be release to:

Spouse_____

Children _____

Parent _____

Other _____

_____ Information is NOT to be released to anyone.

The release of Information will remain in effect until terminated by me in writing.

I further agree that the practice may disclose health information to me in the following manner:

Home # _____ Cell # _____ Other_____

If you are unable to reach me:

_____ You may leave a detailed message.

_____ Please leave a message asking me to return your call.

I, _____ (Patient/Parent of minor child), acknowledge that I have received a copy of Ocean Allergy notice regarding Privacy of Personal Health Information.

Signed _____ Date: _____