SAINT CLAIR ALLERGY & ASTHMA CENTER, PLLC

*PLEASE PRINT*

| DATE: | PURPOSE OF VISIT: | | |
|---|---|---|---|
| **PATIENT INFORMATION** | | | |
| PATIENT'S LAST NAME: | FIRST | MIDDLE | SOCIAL SECURITY NUMBER: |
| GENDER: Male Female | BIRTHDATE: | MARITAL STATUS: Single Married Widowed Separated | |
| RACE: African American Asian Native American White Other: | | ETHNICITY: Hispanic/Latino Non- Hispanic/Latino | |
| STREET ADDRESS | | CITY | STATE & ZIP |
| HOME TELEPHONE: ( ) | CELLUAR NUMBER: ( ) | EMAIL ADDRESS: | |
| PREFERRED METHOD OF CONTACT: HOME TELEPHONE CELLULAR PHONE WORK TELEPHONE EMAIL | | | |
| PATIENT EMPLOYER: | | PATIENT OCCUPATION: | |
| PATIENT EMPLOYER ADDRESS: | | | WORK TELEPHONE: |
| **RESPONSIBLE PARTY &/OR GUARDIAN INFORMATION** | | | |
| LAST NAME | FIRST NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER; |
| STREET ADDRESS | | CITY | STATE& ZIP |
| HOME TELEPHONE ( ) | CELLULAR NUMBER ( ) | EMAIL ADDRESS: | |
| EMPLOYER: | | WORK TELEPHONE ( ) | RELATION TO PATIENT |
| **PRIMARY CARE PHYSICIAN OR REFERRING PHYSICIAN INFORMATION** | | | |
| PRIMARY CARE OR REFERRING PHYSICIAN NAME: | | LOCATION & TELEPHONE NUMBER | |
| **PHARMACY INFORMATION** | | | |
| PHARMACY NAME: | | LOCATION & TELEPHONE NUMBER | |
| **EMERGENCY CONTACT** | | | |
| EMERGENCY CONTACT NAME & RELATIONSHIP | | PHONE NUMBER: | |
| **MEDICAL INSURANCE INFORMATION** | | | |
| PRIMARY INSURANCE COMPANY | | SECONDARY INSURANCE COMPANY | |

**A COPY OF MEDICAL INSURANCE CARDS (FRONT & BACK)**
**COPY OF PHOTO IDENTIFICATION OF POLICY HOLDER IS REQUIRED TO FILE CLAIM**
**PLEASE HAND INSURANCE CARDS & PHOTO I.D. TO RECEPTIONIST WITH COMPLETED FORM**

**PATIENT/GUARDIAN ACKNOWLEDGEMENT OF ACCURACY & ASSIGNMENT OF BENEFITS**

I hereby acknowledge financial responsibility of services rendered and accuracy of the completion of this form. I authorize and release information relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree and acknowledge that my signature on this document authorizes my physician/provider to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on claim submitted to my insurance carrier on my behalf or on behalf of my dependents.

| PATIENT/GUARDIAN SIGNATURE | DATE: |
|---|---|

NEW PATIENT EDUCATION

| PATIENT "TO DO LIST" | |
|---|---|
| 01. | BRING THE COMPLETED PATIENT INFORMATION FORMS ***15 MINUTES*** PRIOR TO SCHEDULED APPOINTMENT |
| 02. | BRING CURRENT LIST OF MEDICATIONS. INCLUDE OVER-THE COUNTER MEDICINE, VITAMINS, SUPPLEMENTS |
| 03. | BRING CURRENT INSURANCE REFERRAL IF REQUIRED BY YOUR INSURANCE CARRIER |
| 04. | BRING CURRENT MEDICAL INSURANCE CARDS FOR PHOTOCOPYING |
| 05. | BRING PHOTO IDENTIFICATION CARD FOR PHOTOCOPYING. PHOTO IDENTIFICATION CANNOT BE EXPIRED. |
| 06. | BRING MEDICAL RECORDS THAT ARE IMPORTANT TO YOUR VISIT *(PRIOR SKIN TEST RESULTS, LABS, BIOPSIES, X-RAYS, ETC.)* |
| 07. | CONTACT INSURANCE CARRIER PRIOR TO VISIT FOR ALLERGY TESTING BENEFIT INQUIRY. TESTING CODES: 95004 & 95024 ARE CODES TYPICALLY USED TO BILL FOR THE SERVICE. USE THE TELEPHONE NUMBER ON THE BACK OF YOUR INSURANCE CARD. |
| **PATIENT "REMINDER LIST"** | |
| 01. | DO NOT APPLY LOTION OR FRAGRANCES THE DAY OF VISIT (TO INCLUDE SUBSEQUENT VISITS) |
| 02. | DO NOT TAKE ANTIHISTAMINE MEDICATION SEVEN (7) DAYS PRIOR TO TESTING –SEE LIST BELOW OF COMMON ANTIHISTAMINES |
| 03. | DO NOT TAKE H2 BLOCKERS FIVE (5) DAYS PRIOR TO TESTING *(AXID, PEPCID, TAGAMET, ZANTAC, ETC.)* |
| 04. | CONTINUE TAKING ALL OTHER MEDICATIONS AS PRESCRIBED |
| 05. | WEAR LAYERS OR SHORT SLEEVES TO ALLOW ACCESS TO ARMS |
| 06. | PREPARE FOR YOUR INDIVIDUAL COMFORT LEVEL WITH TEMPERATURE IN THE OFFICE |
| 07. | EAT PRIOR TO YOUR APPOINTMENT TIME |
| 08. | BRING AN ACTIVITY TO DO DURING WAIT TIME DURING TESTING |
| 09. | BE PREPARED TO SPEND APPROXIMATELY THREE (3) HOURS FOR THE INITIAL NEW PATIENT VISIT |
| 10. | SMALL CHILDREN WHO ACCOMPANY PATIENT TO VISIT DO NOT TOLERATE THE LONG TIME FRAME OF THE INITIAL VISIT. IF POSSIBLE, PLEASE MAKE CHILDCARE ARRANGEMENTS. |
| 11. | CONTACT THE OFFICE WITH ANY QUESTIONS OR CONCERNS (586.884.5656) |

**STOP** ALL ANTIHISTAMINES AT LEAST SEVEN (7) DAYS PRIOR TO YOUR APPOINTMENT

**NAME BRAND ANTIHISTAMINES**

THE COMMON ANTIHISTAMINES ARE LISTED BELOW. THIS IS NOT A COMPLETE LIST OF ALL ANTIHISTAMINES. OVER-THE -COUNTER MEDICATIONS AND COMBINATION DRUGS CONTAIN ANTIHISTAMINES. IF YOU NEED TO VERIFY IF A MEDICATION YOU ARE TAKING CONTAINS AN ANTIHISTAMINE, PLEASE DO NOT HESITATE TO CONTACT OUR OFFICE, YOUR PRIMARY CARE PHYSICIAN, OR YOUR LOCAL PHARMACIST.

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|---|---|---|
| ADVIL PM | DECONAMINE | RYNATUS |
| ALAVERT | DIMETAINE COUGH SYRUP | SEMPREX |
| ALKA SELTZER PLUS COLD | DIMETAPP COLD & ALLERGY | SINULIN |
| ALLEGRA | DURA-VENT | TAVIST |
| ANTIVERT | EXTENDRYL | TRINALIN |
| ASTELIN NASAL SPRAY or DYMISTA | HYCOMINE COMPOUND | TUSSIONEX |
| ASTEPRO OR PATANASE NASAL SPRAY | KRONOFED | TYLENOL ALLERGY |
| ATARAX | NOLAMINE | TYLENDOL COLD |
| ATROHIST | NOLAMINE | TYLENOL FLU |
| BENADRYL | NOLAHIST | TYLENOL PM |
| BROMFED | PERIACTIN | VISTARIL |
| CLARITIN | PHENERGAN | XYZAL |
| CLARINEX | RONDEC | ZYRTEC |
| CODIMAL DH SYRUP | | |
| **GENERIC ANTIHISTAMINES** | | |
| ACRIVASTINE | CYPROHEPTADINE | HYDROXYZINE |
| AZELASTINE | DESLORATADINE | LORATADINE |
| BROMPHENIRAMINE | DIPHENHYDRAMINE | PROMETHAZINE |
| CETIRIZINE/LEVOCETIRIZINE | FEXOFENADINE | PYRILAMINE |
| CHLORPHENIRAMINE | | |
| **EYE DROPS WITH ANTIHISTAMINES (STOP 5 DAYS PRIOR TO APPOINTMENT)** | | |
| BEPREVE | PATADAY | OPTIVAR |
| ELESTAT | PATANOL | ZADITOR |
| **GASTRITIS/HEART BURN MEDICATION WITH ANTIHISTAMINES (STOP 5 DAYS PRIOR APPOINTMENT)** | | |
| AXID | TAGMET | ZANTAC |
| PEPCID | | |

A. **ASTHMA MEDICATIONS SHOULD NOT BE STOPPED PRIOR TO ALLERGY TESTING. EXAMPLES OF ALLERGY MEDICATIONS: SINGULAIR, ACCOLATE, ZYFLO, OR ANY ANTI-INFLAMMATORY MEDICATIONS.**

B. **ANTIDEPRESSANTS CAN INTERFERE WITH ALLERGY TESTING. DO NOT STOP ANY PRESCRIBE MEDICATION WITHOUT CONSULTING WITH THE PRESCRIBING PHYSICIAN.**