ADVANCED ALLERGY IMMUNOLOGY & ASTHMA, P.C.
Denis A. Bouboulis, M.D., FACAAI, FAACA
Diplomate American Board of Allergy & Immunology Darien Professional Building • 106 Noroton Avenue • Darien, CT, 06820 Phone: 203.655.9904 • Fax: 203.656.1416

Appointment Date:_________ Allergy:____ Other:_______________

Patient's Name: ____

Home Address: ____

City:______________ State:___ Zip:______ D.O.B. :____/_____/_____

Email Address: ___________________ Cell Phone:______________

Home Phone: _______________ Primary Care Physician:___________

Name of Pharmacy: _____________ Pharmacy Number:____________

<u>*Names of Other Family Members Who Are Also Patients:</u>

1.__________________________ 2.__________________________

3.__________________________ 4.__________________________

5.__________________________ 6.__________________________

Insurance Information

Name of Responsible Party:_______________________________

Date of Birth:_________ Name of Insurance:_______________

I authorize payment of medical benefits directly to the physician for services rendered. I also request payment government benefits to either myself or the party accepting assignment.

I understand that I am responsible for services rendered if a valid referral/authorization for services is not on file at the time of my visit. I also understand that it is my responsibility to inform your office of any change to my insurance coverage. If I fail to do so, I am responsible for any uncovered services. Co-pay is due at the time of your visit.

Print Name: ________________________________ Date:_____________

Signature of Responsible Party: ________________________ Date:_________________

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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New Immunology Patient Questionnaire

Please mark in the chart below if and when you have experienced any of the following symptoms and the severity. **0-None 1- Mild 2- Moderate 3- Severe**

Symptoms	Severity (Circle One)				Comments
Decreased sensation in extremities	0	1	2	3	
Fatigue	0	1	2	3	
Tingling, Numbness of extremities	0	1	2	3	
Burning pain in muscles/extremities	0	1	2	3	
Muscle Weakness	0	1	2	3	
Fainting Spells upon standing	0	1	2	3	
Difficulty Walking	0	1	2	3	
Back pain radiating down extremities	0	1	2	3	
Bowel/ Bladder Problems	0	1	2	3	
Twitching of muscles	0	1	2	3	
Involuntary contraction of muscles	0	1	2	3	
Other:________________	0	1	2	3	

Patients Name:______________________________ DOB:__________ Date:__________

Patient's / Responsible Parties Signature:______________________________________

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FINANCIAL POLICY

WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF SOME OF OUR FINANCIAL POLICIES.

INFORMATION REGARDING YOUR INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please Note: In certain rare circumstances - and in our sole discretion- we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided to you.)

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

TYPES OF PAYMENT; DISHONORED CHECKS

Our office accepts [*e.g., cash, personal checks, Master Card, Visa, American Express*]. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of [$*40.00*], which shall be due and owed immediately.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Balances that remain outstanding for a period of 90 days or more may be referred to our collection agency or attorneys' office. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). In accordance with Connecticut law, we charge a fee beginning at .65 cents a page, and have up to 30 days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records.

MISCELLANEOUS FEES

Certain services (e.g., phone consultations, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. **By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.**

____

Signature of Patient or Responsible Party

____

Print Name of Patient and Responsible Party (if any)

____

Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices periodically and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

By signing below I am acknowledging that I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____ DOB_______________

Relationship to Patient:____

Signature:____ Date:_______________

I have attempted to obtain the patients signature in acknowledgment of our offices Notice of Privacy Practices, but was unable to do so as documented below. Date:___________

Reason:____

____ Initials:__________

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http://advanced-allergy.com/

Cancellation & Missed Appointment Policy

Our goal at Advanced Allergy, Immunology & Asthma is to provide you with convenient, accessible, high quality medical care. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive promptly for all scheduled appointments, or cancel the appointment 48 hours in advance. This policy allows us to make better use of our available appointments for those patients in need of medical care.

You may cancel your appointment by contacting our office during normal business hours at (203)655-9904.

Fees for missed/cancelled appointments

Effective March 1st, 2018, Advanced Allergy, Immunology & Asthma will begin to charge patients when they do not present for scheduled appointments. Failure to cancel or re-schedule the appointment within 48 hours of the scheduled appointment time will result in a fee for missed appointment, the fees are outlined below. This fee will not be submitted to the patient's health plan; it will be charged to the patient.

Fee Structure

New PANS/PANDAS appointment is $500.00
New Lyme Appointments $250.00
New Allergy patient appointment is $100.00
Testing/Procedures $40.00
Standard Office Visit $40.00

By signing below I am pre-authorizing Advanced Allergy, Immunology & Asthma to use the payment information (Credit/debit card) on file to charge for the applicable fees. If the payment information provided is invalid, I understand that I will be billed for the applicable fee. I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments.
Repeated "missed appointments" may result in discharge from the practice.

Patient Name:______________________________ DOB: ____________

Patient/ Responsible Party Signature: ______________________________

Credit Card#: ______________________________Expiration Date: ____ / ____

3 Digit Security Code: ____________ (Located on back of card) 4 Digit Security Code: ____________ ((Amex) Located on Front of card)

Card Holders Name (Please Print Clearly):______________________________

Billing Address:______________________________

____