Asthma & Allergy Physicians of RI, Inc.
New Patient Information Sheet

Full Name: _____Date of Birth: _____Gender:_____

Address: _____City:_____State:_____Zip Code: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Race: White_____ Hispanic_____ Non-Hispanic_____ African American_____ Native American_____
Asian_____ Other_____ Prefer not to answer_____

Social Security :_____-____-_____(required) Email Address: _____

Employed by: _____ Spouse, Parent, Guardian Name: _____

Primary Care Physician_____Referring Physician_____

Primary Insurance: _____ID: _____Effective Date: _____

Insured's Name: _____ Date of Birth: _____ SSN# _____

Secondary Insurance: _____ID: _____Effective Date: _____

Secondary Insured's Name: _____ Date of Birth: _____ SSN#_____

Insured's Employer (Primary) _____ Secondary: _____

Emergency Contact: _____Phone: _____ Relationship: _____

I authorize AAPRI to forward progress reports to my PCP and/or referring providers as needed.
Yes_____ No_____ Initial _____

Consent for Healthcare of Minor:

By signing below, I give consent for AAPRI to treat my son/daughter in the event that a parent or legal guardian is not able to accompany him/her to the appointment, but if he/she is accompanied by a responsible adult who represents me. This may include, but not necessarily be limited to: physical exams, skin testing, allergy injections and issuing prescriptions in my absence. This agreement will be in effect until revoked by me in writing.

Signature of Parent or Guardian: _____ Date: _____

Billing Procedure:

This office participates with most insurance carriers in the state, as well as several carriers out of state. If you have health coverage with any of these carriers, we will automatically bill them for their contracted portion of you care. In most other situations we will provide you with a copy of your encounter form, which you may then submit to the carrier for reimbursement, the encounter form has the information required by most insurance companies. Your signature is required in all cases where we will be submitting on your behalf to the carrier.

Signature: _____ Date: _____

Asthma & Allergy Physicians of RI

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Asthma & Allergy Physicians of Rhode Island. I assign and authorize payments to Asthma & Allergy Physicians of Rhode Island. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusion, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for fees not paid in full, co-payments, and policy deductible and co-insurance except where my liability is limited by contract or State or Federal Law.

_____ _____

Signature of Patient and/or Guardian Date

_____ _____

Printed Name of Patient and/or Guardian Relationship to Patient

_____

Witness and Date

Asthma & Allergy Physicians of Rhode Island

ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have either been provided a copy or have seen Asthma & Allergy Physicians of Rhode Island notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Asthma & Allergy Physicians of Rhode Island and how I may obtain access to and control this information.

_____
Date

_____
(Print) Patient's Name

_____
Signature of Patient or Personal Representative

_____
(Print) Name of Personal Representative (if applicable)

_____
Relationship to Patient

(this section to be completed if written acknowledgement is not obtained)

We have made a good faith effort to obtain this individual's acknowledgement, but the acknowledgement was not received for the following reason(s):

___ The individual refuses to sign or otherwise fails to provide acknowledgement

___ The individual was mailed a copy of the Notice and did not return his/her receipt of acknowledgement

___ Other _____

Completed by: _____

Asthma & Allergy Physicians of Rhode Island

☐ I give permission for Asthma & Allergy Physicians of RI to "web-enable" me. This will allow me to have access to my chart online. My email address is: _____ **OR**

☐ I do not wish to be web-enabled.

☐ I give Asthma & Allergy Physicians of RI to contact me by text message at the following number:

_____ **OR**

☐ I do not wish to be texted.

☐ I would like to receive AAPRI's monthly e-newsletter.
My email address is:_____

Appointment Cancellation Policy Agreement:

Asthma & Allergy Physicians of RI is committed to providing exceptional patient care, including doing our best to accommodate everyone's scheduling needs. If you are unable to keep your appointment, **please call us at (401)-751-1235 by 12:00 PM (noon) the day prior to let us know**. For Monday appointments, please call by noon on *Friday.* If prior notice is not given, **you will be required to pay a missed appointment fee of $50.00.** This fee is not covered by your insurance company, and will be considered an out-of-pocket expense.

Copays & Payments

We make every effort to avoid any misunderstandings regarding your medical insurance. Please be aware that the amount that you are quoted may be an **ESTIMATE ONLY.** It is the patients' responsibility to know and understand their insurance copayments and limitations, but our staff is happy to work with you and your insurance company to get the most accurate information. Any balances not paid by your insurance company are your responsibility. By signing below, you are acknowledging that you have read and understand our office policies.

Name: _____ Date: _____

Credit Card # for Missed Appointment Fee: _____

Exp: _____ CVV: _____

Signature: _____

Asthma & Allergy Physicians of Rhode Island

Patient Name: _____ Date of Birth: ____/____/_____

Today's Date: _____ Referring Physician, person or source:_____

Please answer the following questions as accurately as possible, since they will help us better assess your problem(s).

Please describe the reason for your visit today:

Have you ever been diagnosed with any of the following conditions?

(please circle the appropriate answer)

Asthma:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
Breathing Problems:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
Migraines:	Yes/No	If yes: Age of Onset: _____	Mild/Moderate/Severe
Sinus Trouble:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
Hay Fever:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
(itchy eyes, runny or stuffy nose, sneezing)			
Hives:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
Eczema or Rashes:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
Food Reactions:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
If yes, describe incident: _____			
Insect Bite Reactions:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
Frequent Reactions:	Yes/ No	If yes: Age of Onset: _____	Mild/ Moderate/ Severe
If yes, describe problem: _____			

Current Medications:

(Please list ALL medications including any prescriptions, over-the-counter & Herbal treatments)

Medication: _____ Dose: _____
Medication: _____ Dose: _____
Medication: _____ Dose: _____
Medication: _____ Dose: _____
Medication: _____ Dose: _____

How did you hear about us? _____

What do you hope to gain from your visit to our practice? _____

_____

Previous Allergy Treatment: (please indicate what you've tried)

Drug Allergies (describe reaction):

Past Medical History:

Hypertension: Yes ___ No____ Onset: _____
Diabetes: Yes ___ No____ Onset: _____
Heart Disease: Yes ___ No____ Onset:_____
Chronic Bronchitis/ Emphysema/ Pneumonia: Yes ___ No___ Onset: _____
Abdominal bloat: ____ Constipation: ____ Diarrhea: ____ Reflux/heartburn: _____

If yes, explain onset and current treatment plan above

Recent Hospitalization: Yes___ No ___ If yes, explain reason for visit, and dates you were there.

Do you think your diet may be contributing to your symptoms? Yes___ No___
Have you had a recent chest X-ray or Sinus Imaging? Yes____ No ____
Family History of Asthma: Yes__ No___ Hay fever: Yes___ No ___ Eczema: Yes___ No ___
Family History of Cancer: Yes___ No___ Types: _____
Have you ever smoked? Yes___ No___ If yes, how many years? _____
Do you presently smoke? Yes___ No ___ If yes, how many cigarettes daily? _____
Do other members of your household smoke? Yes____ No____ Do they smoke indoors? Yes___ No___

Please rate your willingness to try each of the following:

Diet, including eliminating foods to identify triggers:

Not interested				Somewhat interested					Very interested
1	2	3	4	5	6	7	8	9	10

Supplements, vitamins, probiotics or other replacements:

Not interested				Somewhat interested					Very interested
1	2	3	4	5	6	7	8	9	10

<u>Do you suffer from these symptoms? If so, what your most severe months?</u> (Please circle)

Runny or Stuffy Nose:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Itchy Nose:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sneezing:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Itchy Eyes:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Coughing:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing or Coughing w/ Exercise:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Skin Problems:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Please list any factors that worsen your symptoms (i.e. dust, animal dander, pollen, etc.)

Previous Allergy Evaluation and Therapy

Have you ever had skin testing? Yes_____ No_____
If yes, date of testing: ___/___/_____ Physician's Name: _____

Results:

Have you ever received allergy immunotherapy (allergy shots)? Yes____ No____
Oral or sublingual immunotherapy (allergy drops)? Yes____ No____

Dates received: _____

Did you find benefit? Yes_____ No_____

Did you have any problems with the therapy? Yes____ No____

If yes, please explain:

Environmental Survey (if applicable)

What are do you live in? Rural _____ Suburban _____ City _____ Near Water _____

Please describe any important factors about your home environment that may be affecting your symptoms:

Are any rooms in your house damp or musty? Yes____ No____

If yes, please explain: _____

Age of home_____ Type of heating (please circle):

Forced Hot Air	Baseboard	Forced Hot Water	Radiator	Gas Stove	Wood Stove

Air conditioning? Yes___ No___ Central or window? In bedroom? Yes___ No___

Do you have pets? What type? _____

Any pets at work or school? Yes____ No____ Do they spend time in your bedroom? Yes____ No____

Do you have carpeting? Bedroom___ Living Rm _____ Dining Rm_____ Other_____

Type of pillows and blankets (i.e. feather, down, Dacron®, etc.)

_____

Are pillows and mattress encased in Allergy-Proof covers?
Pillows: Yes____ No____ Mattress: Yes____ No____

What type of work do you do? Please list any factors that might affect your symptoms

Have you missed any time from work or school due to your allergies or asthma? Yes_____ No_____
If yes, how much time? _____

Do you have other exposures or recreational hobbies that might aggravate your allergies or asthma?

_____

_____

Thank you for completing these forms. We look forward to meeting you!

Asthma and Allergy Physicians of Rhode Island, Inc.

Research Division

AAPRI Clinical Research Institute

470 Tollgate Road

Warwick, RI 02886

401-681-4960

One of the ways Dr. Zwetchkenbaum stays on top the "State of the Art" treatments is his involvement in Clinical Research Studies. Clinical Trials involve people like you who volunteer to participate in carefully conducted investigations that ultimately uncover better ways to treat, prevent, diagnose and understand human disease.

Ninety percent of our patients who participate request to be involved in additional trials. Answering *yes* only allows us to contact you, if you may be eligible to participate, per study criteria. It *does not* commit you to participating.

Asthma and Allergy Physicians of RI may use your protected information to aid in identifying whether you may qualify for a research study conducted by our Research Division. We will only contact you to discuss the option of enrolling in a clinical study that you may qualify for.

Would you like to be contacted if you may criteria for a study?

(Please check one)

☐ Yes, I would like to be contacted if I am potentially eligible

Patient's Name and DOB: _____

Home Phone: _____ Cell Phone: _____ call text (circle one or both)

Email: _____

Signature: _____ Date: ____/____/_____

☐ No, I would rather not be contacted, even if I were potentially eligible

Signature: _____ Date: ___/___/_____