



AAPRI
Asthma & Allergy
 PHYSICIANS OF RHODE ISLAND

Patient Name: _____ Date of Birth: _____ Gender: M F Other
 Address: _____ City: _____ State: _____ Zip: _____
 Tel.: (Home): _____ (Cell): _____ E-mail: _____
 Emergency Contact Name: _____ Tel.: _____ Relationship: _____
 Primary Care Physician: _____ Referring Physician: _____

I, _____, authorize AAPRI to forward progress reports to my PCP and/or referring providers.

Race/Ethnicity (*please circle*): White Hispanic Non-Hispanic African American Native American Asian Other

Primary Insurance Name: _____ Member ID: _____ Effective Date: _____ Guarantors Full Name: _____ Guarantors Date of Birth: _____ Guarantors Social Security Number: _____	Secondary Insurance Name: _____ Member ID: _____ Effective Date: _____ Guarantors Full Name: _____ Guarantors Date of Birth: _____ Guarantors Social Security Number: _____
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Consent for Healthcare Treatment:

By signing below, I agree to receive treatment provided by the providers at Asthma & Allergy Physicians of Rhode Island until withdrawn by signee or guardian. This may include, but not be limited to physical examination, skin and breathing tests, injections, and breathing treatments.

Signature: _____ Date: _____
 Name Printed: _____ Relationship: _____

Consent for Billing, Assignment of Benefits and Acknowledgement of Financial Responsibility:

By signing below, I hereby assign all health insurance benefits and authorize payments to Asthma & Allergy Physicians of Rhode Island for services rendered. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I acknowledge and understand that I am legally responsible for fees not paid in full, co-payments, policy deductible and co-insurance except where my liability is limited by contract or State or Federal Law.

Signature: _____ Date: _____
 Name Printed: _____ Relationship: _____

Acknowledgement of Receipt of our Notice of Privacy Practice:

By signing below, I acknowledge that I have read Asthma & Allergy Physicians of Rhode Island's Notice of Privacy Practice, via office posting or requesting a physical copy, therefore I understand how my health information may be used and disclosed by "AAPRI", as well as how I may obtain access and control of my health information.

Signature: _____ Date: _____
 Name Printed: _____ Relationship: _____

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What brings you into AAPRI? _____

What is your desired outcome as our patient? _____

Current Medications:

(Please list ALL medications including any prescriptions, over-the-counter medications and herbal treatments)

Medication: _____ Dosage: _____ Started (approximately): _____

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Known Allergies:

(Please describe reaction)

Source: _____ Reaction: _____

Source: _____ Reaction: _____

Source: _____ Reaction: _____

Medical History

Hypertension: Yes No. If yes, onset: _____

Diabetes: Yes No. If yes, onset: _____

Heart Disease: Yes No. If yes, onset: _____

Bronchitis/Emphysema/Pneumonia: Yes No.

If yes, onset: _____

Abdominal bloating: Yes No. If yes, onset: _____

Constipation: Yes No. If yes, onset: _____

Diarrhea: Yes No. If yes, onset: _____

Reflux Heartburn: Yes No. If yes, onset: _____

Asthma: Yes No. If yes, onset: _____

Hay Fever: Yes No. If yes, onset: _____

Eczema: Yes No. If yes, onset: _____

Cancer: Yes No. If yes, onset: _____

Cancer Type/s: _____

Family History

Asthma: Yes No. If yes, who: _____

Eczema: Yes No. If yes, who: _____

Allergy: Yes No. If yes, who: _____

Environmental History

Flooring - Carpeting Wood

A.C. - Central Window

Heat - Baseboard Radiator Forced

Residing Area - Rural City Suburbs

Is your environment damp/moist?

Yes No

Animals - Yes No

If yes, what kind: _____

Social History

Smoking

No, never

Yes, currently. Daily intake? _____

No, but previously for _____ years

Household smokers: Yes No

If yes, Outdoor Indoor

Testing History

Have you had a recent X-ray or

Sinus Imaging? Yes No

If yes, approximate date: _____

Skin tested previously? Yes No

If yes, approximate date of testing: _____

Physician Name: _____

Results: _____

Please Rate Your Willingness to Try Each of The Following

Exploring dietary options, including eliminating foods, to identify triggering foods: **Not Interested Somewhat Very**

Exploring supplemental, vitamin, probiotics or other replacement options: **Not Interested Somewhat Very**

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Contact Agreement

(Please check)

I give "AAPRI" permission to "web-enable" me for the Healow portal, granting me accessing my medical and account details, as well as optimal communication to the AAPRI providers and staff.

Sign up E-mail: _____

I do not wish to be web-enabled, and I understand the primary means of practice communication is through the Healow portal. Resulting in reduced phone support.

Appointment Cancellation Policy Agreement

Asthma and Allergy Physicians of Rhode Island is committed to providing exceptional patient care, including doing our best to accommodate everyone's scheduling needs. If you are unable to keep any of your appointments, including testing or procedures, please contact us through the Healow portal, or at 401-751-1235, no less than 24 hours in advance. For appointments on Monday, please contact the practice by noon, the Friday before. If prior notice is not given, you will be required to pay a missed appointment fee upwards to \$150.00. This fee is not covered by your insurance company and will be considered an out-of-pocket expense.

Copays and Payments Agreement

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 patient's responsibility to know and understand their insurance co-payments 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 financial responsibilities. Overdue balances may result in account deactivation, resulting in the inability to schedule new appointments. Please assist in keeping accounts up to date by providing card details below.

Name on card: _____ | Expiration Date: _____

Card number: _____ | CVV: _____

Physical copies of this registration form will be destroyed upon upload to the electronic medical records system.

By signing below, you acknowledge that you have read and understand our office policies outlined on this registration form

Signature: _____ Date: _____

Name Printed: _____ Relationship: _____

Clinical Research Institute

470 Toll Gate Road

Warwick, RI 02886

401-681-4960

One of the way Dr. Zwetchkenbaum stays on top of the “State of the Art” treatments is with his involvement in the 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 to see if you may be eligible to participate, according to study criteria. It **does not** commit you to participating.

Asthma and Allergy Physicians of Rhode Island 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 enrolling in clinical study for which you may qualify.

Would you like to be contacted if you are interested in qualifying for a study? *(Please check)*

Yes, I would like to be contacted if eligible for participation

E-mail: _____ Home: _____ Cell: _____ Call Text (Circle preference/s)

Patients Name: _____ Patient’s Date of Birth: _____

Patients Signature: _____ Date: _____

No, I decline to be contacted, even if I were potentially eligible for participation

Patients Name: _____ Date: _____

Patients Signature: _____ Date: _____

Thank you for completing our documents. We look forward to caring for you!