



## Atlantic Allergy, Asthma & Immunology Associates of NJ, LLC

802 West Park Avenue  
Ocean, NJ 07712  
732-695-2555

8 Tindall Road  
Middletown, NJ 07748  
732-671-0066/7676

Dear New Patient:

**Welcome to Atlantic Allergy, Asthma & Immunology!** We are pleased that you have chosen our practice for your allergy and asthma related health care needs. Our goal is to exceed your expectations. We look forward to seeing you

on \_\_\_\_\_ at \_\_\_\_\_ in our \_\_\_\_\_ office.

Here is what to expect on your initial visit:

### “How long will it take?”

Plan to be here approximately **1 ½ to 2 hours**. Skin testing is tolerated well even by small children. Please try to leave other children at home for this initial visit.

### “What should I do to prepare for this visit?”

- **STOP ALL ANTIHISTAMINES PRIOR TO YOUR VISIT. A LIST TO GUIDE YOU IS INCLUDED ON THE NEXT PAGE.** If you have any questions, please call our staff.
- **WITHHOLD, ONLY IF POSSIBLE, your nebulizer treatment or rescue inhaler 4 HOURS** prior to your visit.
- **DO NOT DISCONTINUE any other prescription medications.**
- Bring a list of all prescription and over-the-counter medications with you or, if possible, bring all your current medications with you.
- Bring your **insurance card** and your **REFERRAL** if required by your insurance. Your visit could possibly be rescheduled if you fail to bring the proper paperwork.
- Fill out the enclosed forms and **BRING THEM WITH YOU** on the day of your first visit. Please **DO NOT** mail them back to the office.
- Bring any **SINUS CT SCANS, CHEST X-RAYS AND REPORTS.**
- **REFRAIN FROM USING ANY PERFUMES OR COLOGNES ON ALL VISITS TO OUR OFFICE.**
- A **\$50.00 FEE** WILL BE CHARGED FOR MISSING THIS APPOINTMENT OR CANCELLING WITH LESS THAN 24 HOUR NOTICE and must be paid before rescheduling.

### “How much will it cost?”

Typical consultations run between \$150 and \$400 depending upon the nature and complexity of your problems. Skin testing and breathing tests are at an additional cost. We will recommend a treatment plan for you at the time of your visit.

**Copayments are to be paid at the time of service as per your insurance company and our office policy.** Failure to do so could result in a \$10.00 charge to cover our billing costs. In addition, coinsurances and deductibles applied to your account by your insurance company are due either upon receipt of your **first** statement or prior to **additional services** being rendered, **whichever comes first.**

### “What insurance plans do you accept?”

Atlantic Allergy, Asthma & Immunology participates with many insurance plans including Horizon Blue Cross/Blue Shield, Aetna, Cigna, Medicare, Oxford, United Healthcare, Qualcare, MultiPlan, Healthnet and PHCS, among others. However, this office **does not** participate with **Horizon NJ Health**. Since we frequently review and expand our participation, it is a good idea to call your insurance company before your visit to ask if the physician in our practice is a participating provider for allergy and immunology in your specific network.

Again, welcome to our practice. If you have any other questions, please call and we will be happy to answer them for you.

**MEDICATIONS TO REFRAIN FROM PRIOR TO TESTING VISITS**

**ANTI-HISTAMINES TO  
STOP FOR 7 DAYS**

CLARINEX  
XYZAL

**ANTI-HISTAMINES TO  
STOP FOR 3 DAYS**

ALAVERT  
ALLEGRA (Fexofenadine)  
ANTIVERT  
ATARAX (Hydroxyzine)  
BENADRYL (Diphenhydramine)  
CHLOR-TRIMETON  
CLARITIN (Loratadine)  
DIMETAPP  
RYNA 12  
RYNATAN  
Zyrtec (Cetirizine)  
*and any other antihistamine*

**ANTI-HISTAMINES TO  
STOP FOR 1 DAY**

ASTELIN (nasal spray)  
PATANASE (nasal spray)  
PATANOL (eye drops)  
PATADAY (eye drops)  
PEPCID (famotidine)  
SINGULAIR  
ZANTAC (Ranitidine)

## OFFICE POLICY REGARDING PAYMENT OF SERVICES

In order to establish optimal relations with our patients and to avoid misunderstandings regarding our payment policies, we ask you to read and sign the following:

Payment is due at time of service unless we accept assignment with your insurance company.

If we accept assignment with your insurance company, your copayment is due at time of service.

If we accept assignment with your insurance company, it is your responsibility to provide the receptionist with all necessary information needed to process your claim, including but not limited to:

1. Copy of valid insurance card
2. Subscriber's name, birth date and social security number
3. Valid referral, if required, from your primary care physician.

If any of the above information is not available at the time of your visit, we may reschedule your appointment until the information requested is available. If a required referral is not presented, payment must be made at time of service and we shall not file an insurance claim.

A divorce decree is a legal agreement binding only upon the two parties who made the agreement. Therefore, if the divorce decree states the father is responsible for medical bills, the mother is still responsible for paying that bill at time of service. The father is responsible for reimbursing her.

After a claim is processed by your insurance company, we will bill you for any balance due to this office, such as deductibles, copayments and co-insurance. You are ultimately responsible to pay the medical bill if the assignment of benefits is not honored in whole or in part.

Your signature below indicates that you understand and accept this policy. Furthermore, your signature authorizes this office to release medical information necessary to process your insurance claims and allows the use of signature on file in lieu of your signature. You herein authorize payment of medical benefits to this office.

\_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT FULL NAME

# PATIENT INFORMATION

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT NAME _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS _____		_____/_____/_____ PATIENT BIRTHDATE
CITY, STATE _____ ZIP CODE _____		FULL TIME STUDENT <input type="checkbox"/> PART TIME STUDENT <input type="checkbox"/>
(_____) _____ HOME PHONE	(_____) _____ PATIENT/PARENT WORK PHONE	_____-_____-_____ SOCIAL SECURITY #
(_____) _____ CELL PHONE	MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW	
EMERGENCY CONTACT - NAME AND NUMBER (_____) _____		

PRIMARY CARE PHYSICIAN	REFERRED BY
PHYSICIAN'S NAME _____	NAME _____ (_____) _____ PHONE
ADDRESS _____ (_____) _____ PHONE	ADDRESS _____
CITY, STATE _____ ZIP CODE _____	CITY, STATE _____ ZIP CODE _____

PRIMARY INSURANCE COMPANY	
NAME OF COMPANY _____	POLICY # _____ GROUP # _____
ADDRESS TO SEND CLAIMS _____	GROUP NAME _____ COPAYMENT AMOUNT _____
CITY, STATE _____ ZIP CODE _____	PATIENT'S RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE TO THE POLICY HOLDER: <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____
POLICY HOLDER _____ SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	_____/_____/_____ POLICY HOLDER'S BIRTHDATE
ADDRESS _____	_____-_____-_____ SOCIAL SECURITY #
CITY, STATE _____ ZIP CODE _____	POLICY HOLDER'S EMPLOYER _____
POLICY HOLDER'S WORK PHONE _____	EMPLOYER'S ADDRESS _____
IF PATIENT IS A CHILD, OTHER PARENT'S NAME AND WORK PHONE _____	_____ CITY, STATE _____ ZIP CODE _____

SECONDARY INSURANCE- ONLY COMPLETE THIS SECTION IF INSURANCE IS SECONDARY TO MEDICARE OR IF BOTH PRIMARY AND SECONDARY INSURANCE ARE HORIZON BCBS PLANS (PLEASE NOTE: WE DO NOT PARTICIPATE WITH ALL MEDICARE SUPPLEMENT PLANS)	
NAME OF COMPANY _____	POLICY # _____ GROUP # _____
ADDRESS TO SEND CLAIMS _____	GROUP NAME _____
CITY, STATE _____ ZIP CODE _____	PATIENT'S RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE TO THE POLICY HOLDER <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____
POLICY HOLDER _____ SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	_____/_____/_____ POLICY HOLDER'S BIRTHDATE
ADDRESS _____	_____-_____-_____ SOCIAL SECURITY #
CITY, STATE _____	POLICY HOLDER'S EMPLOYER _____
	EMPLOYER'S ADDRESS _____
	_____ CITY, STATE _____ ZIP CODE _____

# INITIAL VISIT QUESTIONNAIRE

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer all questions (parents should answer for children).

Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace \_\_\_\_\_

Occupation \_\_\_\_\_ Primary Physician's Name \_\_\_\_\_

Briefly describe your symptoms \_\_\_\_\_

List factors that aggravate symptoms (i.e. animals, dust, mold, grass, weather changes, etc) \_\_\_\_\_

Date of onset of symptoms \_\_\_\_\_ Duration of symptoms \_\_\_\_\_ Frequency \_\_\_\_\_

When are symptoms worse? (Circle) Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec All year Variable times

**HOME:** (Circle) Urban Suburban Rural // House Condo/Townhouse Apt // Age of Home \_\_\_\_\_

Heating System: Gas Oil Electric // Forced hot air Baseboard Radiator Woodstove Fireplace (wood / gas)

Humidifier: Central Bedroom Unit // Air Conditioning: Central Bedroom/Wall Unit(s) // Type of Filters \_\_\_\_\_

**BEDROOM:** Single Shared // Flooring: Bare Area rug Carpet Age of Carpet \_\_\_\_\_

Windows: Curtains Valence Shades Blinds // Misc: Shelves Stuffed Animals Plants

**FAMILY / LIVING ROOM FLOORING:** Bare Area rug Carpet Age of Carpet \_\_\_\_\_**BASEMENT:** Finished Unfinished // Damp Musty Dry Wet Crawlspace Dehumidifier

Flooring: Bare Area rug Carpet Age of Carpet \_\_\_\_\_

**PETS:** (How many & how long you have owned pet(s) Dog(s) \_\_\_\_\_ Cat(s) \_\_\_\_\_ Birds \_\_\_\_\_

other pets: \_\_\_\_\_ Do pets go in bedroom? Yes No

Did you ever smoke? Yes No Cigarettes Cigars Presently? Yes No When stopped \_\_\_\_\_ How much per day \_\_\_\_\_

How long have you been/did you smoke? \_\_\_\_\_ Are there (other) smokers in the home? Yes No

## SOCIAL/WORK ENVIRONMENT HISTORY

Occupation: \_\_\_\_\_

Workplace: Chemical Exposure/Type \_\_\_\_\_

Mold (Explain) \_\_\_\_\_

## REVIEW OF SYSTEMS

General:  Weight loss  Fevers  Chill  Fatigue  AchesEyes:  Itch  Burn  Tear  Dry  Blurry Vision  Change in visionEar:  Pain  Discharge  RingingNose:  Sneeze  Itch  Congestion  Discharge  Bleeding  Postnasal dripThroat:  Sore  IrritationSinus:  Pain  PressureChest:  Pain  Cough  Shortness of Breath  Tightness/pressureGI:  Difficulty swallowing  Stomach pain  Nausea  Vomiting  Constipation  DiarrheaUrinary:  Frequency  Pain with urinationNeuro:  Headache  Dizziness  Numbness  WeaknessSkin:  Rash  Itch  Bruising Joint:  Pain  Arthritis  Muscle PainImmune:  Frequent infections  Enlarged lymph nodesMental:  Anxiety  Depression  Sleep problems

## INITIAL VISIT QUESTIONNAIRE – CONT'D

### PAST MEDICAL HEALTH HISTORY or Circle NONE

- Aids/HIV
- Alcoholism
- Anemia
- Arthritis
- Asthma
- Bee Sting Allergy
- Bleeding Disorder
- Bronchitis
- Cancer
- Cataracts
- Diabetes
- Drug Dependency
- Emphysema
- Epilepsy

- Eye Disease
- Glaucoma
- Gout
- Hay Fever
- Head Injury
- Heart Disease
- Hepatitis
- High Blood Pressure/Hypertension
- High Cholesterol
- Kidney Disease/Stones
- Lactose Intolerance
- Liver Disease
- Migraine Headaches
- Multiple Sclerosis

- Pacemaker
- Phlebitis
- Polio
- Prostate Disease
- Psychiatric Disease
- Rheumatic Fever
- Sinus Disease
- Stomach/Digestive Ulcer
- Stroke/CVA/TIA
- Suicide Attempt
- Thyroid Disease
- Tobacco Use
- Tuberculosis
- Venereal Disease/STD

### PAST HOSPITALIZATIONS, SURGERIES, ILLNESSES or Circle NONE

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### FAMILY ALLERGY, ASTHMA & MEDICAL HISTORY

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#### PAST MEDICATIONS

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#### CURRENT MEDICATIONS

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### LIST ADVERSE REACTIONS TO ANY FOODS, DRUGS, LATEX OR STINGING INSECTS or Circle NONE

FOODS \_\_\_\_\_

DRUGS \_\_\_\_\_

LATEX \_\_\_\_\_

STINGING INSECTS \_\_\_\_\_

PAST HISTORY ALLERGY TESTING - YES / NO

HISTORY OF ALLERGY SHOTS - YES / NO      If yes, when \_\_\_\_\_

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Practice’s Notice of HIPAA Privacy: The Notice regarding Privacy of Personal Health Information has been made available to me. Various copies have been placed in black binders around the waiting room and a copy would be made for me should I request one.

\_\_\_\_\_  
Print Name of Patient                  Patient Date of Birth                  Signature of Patient/Guardian                  Date

II. Designation of Certain Relative, Close Friends and Other Caregivers:

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person’s involvement with my health care or payment relating to my health care.

I wish to be contacted in the following manner (check all that apply):

Telephone, Written and Fax Communication to Relay Laboratory Results

Home Telephone Number: \_\_\_\_\_ Written Communication:  
\_\_\_ OK to leave message with detailed information                  \_\_\_ OK to mail to my home address  
\_\_\_ OK to leave message/report on Answering Machine                  \_\_\_ OK to mail to my office address  
\_\_\_ Leave message with call back number                  \_\_\_ OK to fax to this number \_\_\_\_\_

B. I designate the following persons listed below as persons involved with my healthcare or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship \_\_\_\_\_

C. The following person(s) are not authorized to receive my Patient Health Information:

Print Name: \_\_\_\_\_ Relationship \_\_\_\_\_

III. We perform medical research here. Our clinical researchers may look at your health records as part of your current care or to prepare or perform research. All patient research conducted by us goes through a special process required by law that reviews protections for patients involved in research, including privacy. We will not use your health information or disclose it outside of the practice for research reasons without either getting your prior written approval or determining that your privacy is protected.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian                  Date

**Directions to Ocean Township Office**  
**802 West Park Avenue, Suite 213**  
**Ocean, NJ 07712**  
**732-695-2555**

***TRAVELLING NORTHBOUND ON GARDEN STATE PARKWAY***

Exit 98. Bear right onto Rt 138 East. After two traffic lights, make right onto Rt 18 North. Take Exit 11A for West Park Ave. At traffic light, make left onto Poplar. Go to end, at traffic light, make right onto West Park Avenue. Make a right into driveway before the TD Bank. Our building is directly behind the bank.

***TRAVELLING SOUTHBOUND ON GARDEN STATE PARKWAY***

Exit 105. 1<sup>st</sup> light, make right onto Hope Rd. Make right onto Rt 18 South. Take Exit 12A for West Park Ave (east). Continue through 2 traffic lights. Make a right into driveway before the TD Bank. Our building is directly behind the bank.

***TRAVELLING NORTHBOUND ON ROUTE 18***

Take Exit 11A Deal Rd (east). 1<sup>st</sup> light make a left onto Poplar Ave. At next traffic light, make a right onto West Park Avenue. Continue straight through another traffic light. Look for our neighbor's sign, 804 on the right. Make a right into the driveway before the TD Bank. Our building is directly behind the bank.

***TRAVELLING SOUTHBOUND ON ROUTE 18***

Take Exit 12A West Park Ave (east). Continue through 2 traffic lights. Make a right into driveway before the TD Bank. Our building is directly behind the bank.

***TRAVELLING NORTHBOUND ON ROUTE 35***

Drive through intersection for West Park Avenue and take jughandle to go West across Rt 35. You are now on West Park Ave. Drive past the TD Bank and make a left into driveway. Our building is directly behind the bank.

***TRAVELLING SOUTHBOUND ON ROUTE 35***

Go past Monmouth Mall. Go past Industrial Way Intersection. *Either* take the fork for Kings Highway after the Red Lobster and take Kings Highway to the very end and make a right onto West Park Ave Or take the quick right turn just before Blockbuster Video and make a right onto West Park Ave. Drive past the TD Bank and make left into driveway. Our building is directly behind the bank.

**Directions to Middletown Office**  
**8 Tindall Road**  
**Middletown, NJ 07748**  
**732-671-0066/7676**

***TRAVELLING NORTHBOUND ON GARDEN STATE PARKWAY***

Exit 114. At 1<sup>st</sup> traffic light, make a right. At next traffic light, make a right and then a quick left onto Red Hill Road (very windy road). Go to end and at traffic light make a right onto Kings Highway. Go to the end, make a right onto Route 35 South. Go thru next traffic light and take jughandle, cross over Rt 35 and make a left onto Rt 35 North. Immediately get into right lane. Pass street sign for Kings Highway. Take jughandle for Middletown/New Monmouth/Middletown HS North/Parkway/Tindall Road – bear to the right halfway through the jughandle (putting you onto Tindall Road). Make a left into second driveway. Drive to the end of the building, our suite is the next to the last.

***TRAVELLING SOUTHBOUND ON GARDEN STATE PARKWAY***

Exit 114. At 1<sup>st</sup> traffic light, make a left. At next traffic light, make a right and then a quick left onto Red Hill Road (very windy road.) Go to end and at traffic light make a right onto Kings Highway. Go to the end, make a right onto Route 35 South. Go thru next traffic light and take jughandle, cross over Rt 35 and make a left onto Rt 35 North. Immediately get into right lane. Pass street sign for Kings Highway. Take jughandle for Middletown/New Monmouth/Middletown HS North/Parkway/Tindall Road – bear to the right halfway through the jughandle (putting you onto Tindall Road). Make a left into second driveway. Drive to the end of the building, our suite is the next to the last.

***TRAVELLING NORTHBOUND ON ROUTE 35***

Go over Red Bank Bridge. Pass Siperstein’s Paint Store on right. Get into right hand lane. Pass Spirit’s Liquor Store, First Union Bank and street sign for Kings Highway. Take jughandle for Middletown/New Monmouth/Middletown HS North/Parkway/Tindall Road – bear to the right halfway through the jughandle. Make a left into second driveway. Drive to the end of the building, our suite is the next to the last.

***TRAVELLING SOUTHBOUND ON ROUTE 35***

Pass Sear’s. Pass Middletown Police Department. Pass EMO. Get in right hand lane. Go thru next traffic light and take jughandle, cross over Rt 35 to get onto Rt 35 North. Immediately get into right lane. Pass street sign for Kings Highway. Take jughandle for Middletown/New Monmouth/Middletown HS North/ Parkway/Tindall Road – bear to the right halfway through the jughandle. Make a left into second driveway. Drive to the end of the building, our suite is the next to the last.

***TRAVELLING NORTHBOUND ON ROUTE 36***

Take jughandle for Leonardville Road through Belford junction. Pass St. Mary’s Church on left to traffic light. Make left onto Tindall Road. Pass Middletown HS North on left. Take this **almost** to Rt 35. Our building (Graham Commons) comes up on the right. Make a right into our driveway just past a metal sign of a traffic light. Drive to the end of the building, our suite is the next to the last.

***TRAVELLING SOUTHBOUND ON ROUTE 36***

Make a right off Rt 36 at Main Street Belford. At traffic light, make a right onto Leonardville Road. Pass St. Mary’s Church on left to next traffic light. Make left onto Tindall Road. Pass Middletown HS North on left. Take **almost** to Rt 35. Our building (Graham Commons) comes up on the right. Make a right into our driveway just past a metal sign of a traffic light. Drive to the end of the building, our suite is the next to the last.