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

Full Name:_____ Address:_____

Ste/Apt:____City:_____State:____Zip:_____Postal Code:_____

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

Race:_____Hispanic/Non-Hispanic:_____Language:_____

Date of Birth:_____Gender:_____SS#:_____ E-Mail:_____
(SS – Required)

Employed By:_____Spouse, Parent, Guardian's Name:_____

Primary Care Physician:_____Referring Physician:_____

Primary Insurance:_____ID:_____Effective Date:_____

Insured's Name:_____Date of Birth:_____SS#_____

Secondary Insurance:_____ID:_____Effective Date:_____

Secondary Insured's Name:_____Date of Birth:_____SS#_____

Insured's Employer: (Primary)_____(Secondary)_____

Emergency Contact:_____Phone:_____Relationship:_____

I authorize AAPRI to forward progress reports to my PCP and/ or referring Specialists as needed. Yes___No___Initial_____

CONSENT FOR HEALTHCARE OF MINOR:

Because my son/daughter is a minor (less than eighteen years of age and primarily supported by parent or guardian), I understand and agree that he/she may be evaluated and/or treated by Asthma & Allergy Physicians of Rhode Island staff if I am not present to give consent. This may include but not necessarily be limited to physical exams, skin testing, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature of parent or guardian:_____Date:_____

BILLING PROCEDURE

The 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 your care. In most other situations we will provide you with a copy of our encounter form, which you may then submit to the carrier for reimbursement. This 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 Rhode Island

Patient name:_____Date of Birth:___/___/___

Address:_____

City:_____ State: _____Zip:_____

Telephone: Home:_____Cell:_____Work:_____

Date of Appointment:_____Referring Physician, person, or source_____

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

Please describe your reason for your visit today:

_____

_____

_____

Have you ever had or been diagnosed with any of the following

conditions? (Please circle 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

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

Poison Ivy: 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: Prescription. OTC, Herbal Treatments)

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

_____
_____
_____

Previous Allergy Treatment:

_____
_____
_____

Drug Allergies (Describe Reaction): _____
_____

Past Medical History:

Hypertension: Yes____ No____ _____
Diabetes: Yes____ No____ _____
Heart Disease: Yes____ No____ _____
Chronic Bronchitis/Emphysema/Pneumonia Yes____ No____ _____
_____

If yes, explain onset and current treatment plan above.

Recent Hospitalizations: Yes____ No____
If yes, please explain reason for visit and dates you were there.
_____
_____
_____

Have you had a recent Chest X-Ray or Sinus Imaging? Yes____ No____

Family History:
Asthma: Yes____ No____ Hay Fever: Yes____ No____ Eczema: Yes____ No____
Smoking History:
Have you ever smoked? Yes____ No____ How many years? _____
Do you presently smoke? Yes____ No____ If yes, how many cigarettes daily? ____
If you quit please tell us when you quit:
Do other members of household smoke? Yes_ No_ If yes, in house? Yes_ No_

Do you suffer from these symptoms? If so, what are most severe months? (Please circle)

Runny or Stuffy Nose:	J F M A M J J A S O N D
Itchy Nose:	J F M A M J J A S O N D
Sneezing:	J F M A M J J A S O N D
Itchy Eyes:	J F M A M J J A S O N D
Wheezing:	J F M A M J J A S O N D
Coughing:	J F M A M J J A S O N D
Wheezing or Coughing w/ Exercise:	J F M A M J J A S O N D
Skin Problems:	J F M A M J J A S O N D

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

_____

_____

_____

_____

Previous Allergy Evaluation and Therapy

Have you ever had allergy skin testing? Yes__No_____

If yes, date of testing__/___/___Physicians name_____

Results:_____

_____

_____

Have you ever received allergy immunotherapy (allergy shots)? Yes No____

Dates received:_____

Did you find benefit? Yes___No____

Did you have any problems with shots? Yes__No ____

If yes please explain:

_____

_____

_____

_____

Environmental Survey

Which area 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 of the rooms in your house damp or musty? Yes____ No____
If yes, please explain:

_____

Age of home_____ Type of heating system: Please circle

FHA, Baseboard, FHW, Radiator, Gas stove, Wood stove

Air condition? Yes_No_Central or Window? In bedroom? Yes_No_

Do you have pets? Yes_No_what type? _____

Any pets at work or school? Yes_____No_____

Do pets spend time in your bedroom Yes____No_____

Do you have carpeting? Bedroom_Living Room_Dining Room_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 may 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 & Allergy Physicians of Rhode Island, Inc.

Research Division

AAPRI Clinical Research
Institute 470 Tollgate Rd.
Warwick, RI 02886

One of the ways Dr. Z stays on top of the "state of the art treatments" is his involvement in clinical research trials. 90% of our patients who participate request to be involved in additional trials. You may fit criteria for a trial. Answering yes to "participating" does not commit you to participating; it only allows us to contact you if you are eligible.

Asthma & Allergy Physicians of RI may use your protected information to aid in identifying whether you may qualify for research conducted by our research division. We may contact you to discuss the option of enrolling in a clinical trial.

Would you be interested in a research study?

Yes or No (Please circle one)

(Answering yes does not commit you to any studies)

You may contact me if you feel I may be eligible to enroll as a study patient:

Signature:_____Date:_____

_____

Print patient's name & DOB

I would rather not be approached about any studies even if I were eligible:

Signature:_____Date:_____

_____

Print patient's name & DOB

Asthma & Allergy Physicians of Rhode Island

John Zwetchkenbaum, M.D Joseph Zhou, M.D
Amanda Matteson, PA-C

ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have been either provided a copy or have the 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

_____

(Please Print) Name of patient

_____

(Please Print) Name of personal representative

_____

Signature of patient or personal representative

_____

Description of personal representative's authority

_____

(This section to will be completed if the written acknowledgement is not obtained)

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

- The individual refuses to sign or otherwise fails to provide an acknowledgement
- The individual was mailed a copy of the Notice and did not mail back his/her receipt of acknowledgement.
- Other:_____

Completed by:_____

Asthma
&Allergy
Physicians
of *Rhode Island*

1056 Hope St. Providence, RI 02906
401-751-1235 Fax: 401-751-4744

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 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 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 & Date

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: _____

☐ I do not give permission for Asthma & Allergy Physicians of RI to Web Enable me.

☐ I give Asthma & Allergy Physicians of RI to remind me of my appointment by text to the following number:

_____

☐ I do not wish to be texted.

☐ I would like to receive AAPRI's monthly E-newsletter.

My Email address is: _____

Patient Name:_____

D.O.B. _____

Signature:_____