Creve Coeur
711 Old Ballas Road, Suite 100·St. Louis, MO 63141
Phone: 314-569-0510·Fax: 314-569-1085
O'Fallon
9963 Winghaven Blvd, O'Fallon MO 63368
Phone: 636-265-2886·Fax: 636-265-2908

Dear _____,

Your appointment is scheduled for _____ at _____ O'clock.

We thank you for choosing Allergy and Asthma Consultants! We hope to get you feeling better soon.

Please complete the attached forms and bring to your appointment along with your insurance card and photo ID. If a referral is needed, please have your PCP fax it to us prior to your appointment.

Initial office visits last about two hours. Please arrive 15 minutes before your appointment to complete the check in process.

If you have any questions, please contact our office.

Thank you and we look forward to seeing you soon!

Sincerely,

Robert F. Onder, M.D.

Sonia Cajigal, M.D

Jaclyn Hey, NP

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Please stop all antihistamines before your visit.

The following medications should be stopped **5 days prior** to your appointment:

Zyrtec (cetirizine)

Xyzal (levocetirizine)

Claritin/Alavert (loratadine)

Allegra (fexofenadine)

The following medications should be stopped **3 days prior** to your appointment:

Benadryl (diphenhydramine)

Pepcid (famotidine)

Tagamet (cimetidine)

Zantac (Ranitidine)

OTC cold medications

The following medications should be stopped **1 day prior** to your appointment:

Allergy eye drops (Pataday, Zaditor, etc)

Allergy antihistamine nasal sprays (Astelin, Azelastine, Patanase)

Singulair (montelukast)

Please note:

*Inhalers for asthma and nasal steroid sprays (Flonase, Nasacort, etc.) do not need to be stopped prior to your appointment.

*If you are unable to stop your medications, inform staff once you arrive for your appointment.

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Patient information Form

Patients Name: _____
Last First M.I.

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

DOB:_____ Sex: ◯Male ◯Female SSN:_____

Email address:_____Marital status:◯Single◯Married◯Widowed◯Divorced

Race:◉Asian◯Black/African American ◯Indian Township ◯Mexican American Indian ◯White

Family members who are patients here:_____

Pharmacy:_____Location:_____Phone number:_____

Emergency Contact:_____Relation:_____Phone Number:_____

Primary Care Provider_____ Phone Number_____

If patient is a minor please complete this section

Mother's name: _____ DOB:_____
Last First

Home Phone:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Email address:_____

Father's name: _____ DOB:_____
Last First

Home Phone:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

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Insurance information

Primary Insurance:_____ ID#:_____ Group#:_____

Policy Holder Name:_____ Relationship to patient:_____

Policy Holder DOB:_____ Policy Holder SSN:_____

Secondary Insurance:_____ ID#:_____ Group#_____

Policy Holder Name:_____Relationship to Patient:_____

Policy Holder DOB:_____ Policy Holder SSN:_____

Responsible Party Information:

Name of person responsible for account:_____ DOB:_____

Phone number:_____ Relation to patient:_____

Consent

I give Allergy and Asthma Consultants, P.C. permission to disclose my medical information to:

Family members name:_____Relation:_____

I hereby, assign payment of authorization medical benefits to include major medical benefits to which I am entitle; to be made on my behalf to Allergy and Asthma Consultants, P.C. for any services furnished me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges weather or not paid by said insurance.

Allergy and Asthma Consultants, P.C. does not deny any benefits or services because of race, color, national origin, age, gender, disability, religious or political beliefs. If you feel that have been discriminated against, you may file a Complaint of Discrimination with the manager of this facility. You will not suffer any penalty because you file a complaint.

In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court cost), in the event that I would fail to pay my bill.

Date:_____ Signature:_____

Patient (over 18 years) or responsible party

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New Patient History

Patient's Name:_____DOB:_____
Last *First* *Middle*

How did you hear about our office?

☐ Referred by physician: (name)_____
☐ Referred by family or friend
☐ Facebook
☐ Advertisement
☐ Internet
☐ Other:_____

What is your chief complaint/ Why did you schedule appointment?

_____

Please check box if Yes

Symptoms:

Cough? ☐
Wheeze? ☐
Tight Chest? ☐
Fatigue? ☐
Shortness of breath? ☐

Eye Symptoms:

Itching? ☐
Watering? ☐
Redness? ☐
Puffiness? ☐

Nasal symptoms:

Nasal Drainage? ☐
Sneezing? ☐
Stuffy nose? ☐
Mouth Breathing? ☐
Itch of the roof of your mouth? ☐
Snoring? ☐

Ear Symptoms:

Itching? ☐
Infections? ☐

Skin Symptoms:

Hives? ☐
Rashes? ☐

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Sinus Headache? ☐ Eczema? ☐

Have you had sinus infections? ☐
*If yes, how often?*_____

Do symptoms awaken you at night? ☐
*If yes, which symptoms and how often?*_____

Are you limited in your daily activities? ☐

Do you miss days of work/school because of your illness? ☐
*How many in the last year?*_____

Have you gone to the emergency room because of asthma /allergy episodes? ☐

Have you ever had a life-threatening reaction to?

Foods ☐

Insect stings (bee, wasp) ☐

Rubber/latex ☐

Medical/Allergy Testing
Have you ever had:

Chest X-Ray: ☐
If yes, date of most recent X-Ray:_____*Where was test done*?_____
*Results:*_____

Sinus X-Ray or CAT Scan of sinuses? ☐
*If yes, date?*_____*Where was test done?*_____
Results:_____

Allergy Testing? ☐
*If yes, date of most recent test:*_____*Where was test done?*_____
Results:_____

Have you ever taken allergy shots? ☐
*If yes, how long?*_____ *When?*_____

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Pulmonary Function Testing? ☐

If yes, date of most recent test:_____ *Where was test done?*_____
Results:_____

Do you have any medication Allergies, if yes please list? ☐

List All of your current medications, including over-the-counter medications:

Medication	***Dose***	***How Often***

Have you ever taken prednisone, cortisone, or other steroids (by mouth)? ☐

Smoking/Alcohol

Do you currently smoke? ☐

Have you smoked in the past? ☐
If yes, for how many years?

*How much a day?*_____ *When did you quit?*_____

Does anyone in your home smoke? ☐

Do you drink alcoholic beverages? ☐
If yes, how many drinks per day/week: _____

Animals/Pets:

*What kind of pets and how many?*_____

How long have you had the animal(s):

Caffeine/ Exercise/ Occupation:

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Do you drink caffeine? ☐ How often? _____

Do you exercise? ☐ How often? _____

Occupation: _____

Medical History

Have you ever had:

Bronchitis:	☐	Blood disease:	☐
Pneumonia:	☐	Anemia:	☐
Emphysema:	☐	Osteoporosis:	☐
Exposure to tuberculosis:	☐	Seizures:	☐
Positive TB skin test:	☐	Stomach problems:	☐
Other lung disease:	☐	Have you ever needed oxygen:	☐
Heart Problems:	☐	High blood pressure:	☐
Heart Attack:	☐	High Cholesterol:	☐
Diabetes:	☐	Kidney disease:	☐
Liver disease:	☐		

Have you ever been hospitalized? ☐

If yes, give reason and dates:

Reason for Hospitalization:	***Dates:***

Have you ever had surgery? ☐

If so, give reasons/procedures, dates:

Reasons:	***Procedure/s:***	***Dates:***

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Review of Systems

Do you currently have:

Constitutional

Fatigue: ☐

Fever: ☐

Dermatology

Rash: ☐

Dry or sensitive skin: ☐

Ophthalmology

Blurring of Vision: ☐

Diminished Vision: ☐

Vision Loss: ☐

Urology

ENT

Loss of Smell: ☐

Hearing Loss: ☐

Ringing in Ears: ☐

Increased urination: ☐

Difficulty urinating: ☐

Frequent urination at night: ☐

Neurology

Memory Loss: ☐

Seizures: ☐

Endocrinology

Gastroenterology

Abdominal pain: ☐

Difficulty swallowing: ☐

Heartburn: ☐

Nausea/Vomiting: ☐

Hives: ☐

Hematology/Lymph

Loss of appetite: ☐

Swollen glands: ☐

Musculoskeletal

Joint pain/stiffness/swelling: ☐

Sciatica: ☐

Cardiology

Chest Pain: ☐

Dizziness: ☐

Palpitations: ☐

Psychology

Sleep disturbances:

Depression: ☐

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Cold/Heat intolerance: ☐

Excessive thirst: ☐

Pediatric Patients Only

Length of pregnancy? _____ Months_____

Were there problems during pregnancy, delivery, or newborn period? Sleep disturbances: ☐
If yes, please explain: _____

Birth weight? _____ Lbs. _____Oz.

Has your child had chicken pox? Sleep disturbances: ☐

Has your child had RSV? Sleep disturbances: ☐

Are your child's immunizations up to date? Sleep disturbances: ☐

Research Studies

Dr. Onder and Allergy and Asthma Consultants, P.C. conduct clinical research studies on new allergy and asthma medications.

Would you or your child be interested in participating in a medication study? Sleep disturbances: ☐

Robert F. Onder, M.D.
Sonia Cajigal, M.D
Jaclyn Hey FNP.

Allergy and Asthma Consultants, P.C.

Diplomat's, American Board of Allergy and Immunology

Allergy and Asthma Consultants, PC
Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you anytime. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, financial agreement or your financial responsibility.

1. **DEDUCTIBLES AND CO-INSURANCE**: Many insurance plans now include annual deductibles requiring patients and their families to pay for medical services up to a specified dollar amount before the insurance company will pay for any medical services. Once the annual deductible has been met, patients still may be responsible for a percentage of costs (co-insurance). Deductibles and co-insurance balances for our services will be determined by your insurance company when they process your claims. If you are not enrolled in our Credit Card on File program, we will send you a statement when the claims have been processed**. Patients with unmet deductibles may be asked to pay a deposit at the time of their visit depending on the nature of the visit.**
2. **CO-PAYMENTS**-By contract with your insurance company, we MUST collect your carrier designated co-pay. This payment is expected at the time of service.
3. **INURANCE**: We are participating with most insurance plans. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible. As a courtesy to our patients, we will verify your insurance coverage/out of pocket expenses, if you request. Our verification is not a guarantee of benefits payable by your insurance. If your insurance requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.
4. **RETURNED CHECKS**: A $35.00 service fee will incur with a returned check.
5. **SELF-PAY PATIENTS**: Payment is required at the time of service unless other financial agreements have been made prior to your visit.
6. **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS**: The parent who consents to the treatment of a minor, and the parent signing this form child are responsible for payment of services rendered. Allergy and Asthma Consultants will not be involved with separation or divorce disputes.
7. **BALANCE COLLECTION EFFORTS**: If you have an outstanding past due balance, we may send your account to an outside collection agency.

I have read the above information and agree that, regardless of my insurance status*, I am ultimately responsible for the balance on my account for services rendered.*
In the event that my insurance is billed, I authorize payment of medical benefits to be paid directly to Allergy and Asthma Consultants, PC. I authorize the release of any medical information necessary to process my claims.

Patient Name_____
(Print)

Responsible party (if other than patient) _____
(Print)

Signature of responsible party_____ **Date**_____
(Sign)

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Creve Coeur, MO 63141

Patient Consent for Use and Disclosure of Protected Health Information for Allergy & Asthma Consultants.

With my consent, Allergy & Asthma Consultants, may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Allergy & Asthma Consultants reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices my be obtained by forwarding a written request to Allergy & Asthma Consultants at 711 Old Ballas Road, Suite 100, Creve Coeur, MO 63141.

With my consent Allergy & Asthma Consultants may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assists the practice carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent Allergy & Asthma Consultants, may mail to my home or other designated location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Allergy & Asthma Consultants may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, or patient paperwork with appointment information.

We may disclose information to Midwest Clinical Research for a source of data for medical research. Signing this document, you give permission to Dr. Robert Onder at Midwest Clinical Research to use your health information that identifies you for as a candidate for the research study.

I have the right to request that Allergy & Asthma Consultants restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Allergy & Asthma Consultants use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Allergy & Asthma Consultants may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Patient's Name

_____
Print Name of Patient or Legal Guardian

_____
Date

IF OVER THE AGE OF 18:

Please list any person in the space provided below that you would like to allow us to speak with in regards to your medical care, insurance items, billing and laboratory results among others:

_____
Name

_____
Relationship

_____
Date

711 Old Ballas Road, Suite 100
Creve Coeur, MO 63141

I, _____, hereby give permission to Allergy & Asthma Consultants, PC to access all my medications prescribed to me by other physicians as needed for my medical care.

_____
SIGN

_____
PRINT

_____
DATE