Asthma & Allergy Physicians

PATIENT REGISTRATION FORM (PLEASE PRINT)

Patient Name _____ Date: _____
Last First M Initial

Street Address 1 _____ Street Address 2 _____

City/Town _____ State _____ Zip Code _____

Sex (M/F) _____ Date of Birth _____ Marital Status _____

Phone Numbers:

Home ( ) _____

Cell ( ) _____

Race: (circle one)
American Indian or Alaskan Native
Asian
Black or African American
White Caucasian
Native Hawaiian or other Pacific Islander
Other Race

Language: *(circle one)*
English
Chinese
Cape Verdean Creole
Japanese
Haitian Creole
Russian
Portuguese
Spanish
Sign Language
Other

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Refused to report

Email address _____ @ _____ (parent if patient is under 18)
Circle one ~~Patient Mother Father (Name _____)

Parent/Guardian Name _____ Full time student? **Y or N**
Employed? **Y or N** *Name of Employer* _____

Emergency Contact _____ **Phone (** **)** _____ **Relationship** _____
(relative, friend, etc)

Address _____

(statements will be addressed to financially responsible party)
Responsible Party: _____ DOB: _____ Address _____
If other than patient Street City/Town State Zip

Relationship of patient to Resp. Party. Self Spouse Child Grandchild Parent *(Circle)*

Name of Primary Care Physician _____
First Name Last Name

Address _____ **Phone (** **)** _____
Street City/Town State ZIP

Physician Specialist
(that you may want a report sent to) _____
First Name Last Name Address

Preferred *Local* Pharmacy _____ _____
Name Address

_____ _____ _____ _____
City/Town State Zip Telephone No

Preferred *Mail Away* Pharmacy _____ _____
Name Address

_____ _____ _____ _____ _____
City/Town State Zip Telephone No Certificate Number (Express Scripts or Medco, etc.)

Insurance
Name of Insurance Company _____ Subscriber's Name _____
Subscriber's DOB _____ Identification Number _____ Group Number _____
Effective Date of Coverage _____ Relationship to patient _____ Co- pay amount _____
Subscriber's Employer _____ Does your insurance require a referral? Y or N

Secondary Insurance
Name of Insurance Company _____ Subscriber's Name _____
Subscriber's DOB _____ Identification Number _____ Group Number _____
Effective Date of Coverage _____ Relationship to patient _____ Subscriber's Employer _____

(Rev 5/1/2025)

Privacy Notice Acknowledgement Form

I have had the opportunity to review Asthma and Allergy Physicians' Notice of Privacy Practices. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, the payment of my bills, and health care operations of the practice including possible future participation in clinical research trials. My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider or health plan. This protected health information relates to all my medical conditions and identifies me. The Notice of Privacy Practices for Asthma and Allergy Physicians is available upon my request. Asthma and Allergy Physicians reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice including possible future participation in clinical research trials. Asthma and Allergy Physicians is not required to agree to the restrictions that I may request. However, if Asthma and Allergy Physicians agrees to a restriction that I request, the restriction is binding on Asthma and Allergy Physicians.

Signature _____ Date _____

I give Asthma and Allergy Physicians permission to share my health information with:

_____ _____ _____

Name Relationship to Patient Phone

_____ _____ _____

Name Relationship to Patient Phone

FINANCIAL POLICY

Thank you for allowing us to serve your allergy/asthma needs. As an accommodation to our patients, we have adopted the following payment policy, which will allow us to continue to provide the best care available. Payment is due at the time services are rendered.

TYPE OF PAYMENT: We accept cash, check, Visa, MasterCard or American Express.

INSURANCE: Patients are responsible for payment of all services. Asthma and Allergy Physicians will submit your claims to your insurance company if proper referrals are in place. Some insurance companies apply skin testing, patch testing and pulmonary function tests to a deductible or co-insurance. This will be your financial responsibility.

REFERRALS: Patients who require referrals from their PCP must have them in place for any future visits. If Asthma and Allergy Physicians does not have a current referral in place, the scheduled appointment may have to be rescheduled.

DEDUCTIBLE & CO-INSURANCE: Some insurance companies apply skin testing, patch testing and pulmonary function tests to a deductible or co-insurance. This will be your financial responsibility. I have read, understand and agree with the above Financial Policy. I hereby authorize Asthma and Allergy Physicians to directly bill my insurance for services rendered to me and authorize direct payment to Asthma and Allergy Physicians for these services. I understand that I may be financially responsible for charges not covered by my insurance.

Signature _____ Date _____

MEDICATION POLICY: Requests for medication refills will only be filled Monday through Friday from 9 a.m. to 4:45 p.m. Please be certain to check your medicine supplies periodically to ensure adequate supplies through weekends/holidays.

Signature _____ Date _____

CANCELLATION POLICY: Twenty-four (24) hour notice is required in order to avoid a $40 missed office visit appointment fee or injection appointment fee.

Signature _____ Date _____

CONFIRMATION POLICY

By checking this ☐ box and signing your name below, you agree that we may call you at the number you entered above with reminders, offers and other info, including possibly using automated technology, text and recorded messages. Consent is not a condition of purchase. [Standard rates apply.] Cell Phone Number _____

By giving us your phone number, you consent to receive messages using automated technology, text and recorded messages?

Signature _____ Date _____

*** Please complete carefully and to the best of your knowledge – do not be concerned if you do not know the answer to all of the questions.***

Patient's Name: _____ Date: _____
(please print)
Patient's DOB: _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I AUTHORIZE **Asthma & Allergy Physicians** to extract my external prescription history via the RX HUB service in their electronic medical records system. I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient (or Guardian) Signature _____ Date: _____
(Please list any over-the-counter medications, vitamins and herbals below)

IN ADDITION - Please list all current medications, herbals and vitamins:

Name/Strength/How Often	**Name/Strength/How Often**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies:	**List:**	**Reaction:**
_____		_____

Surgical History:

Procedure(s)	Date	Procedure(s)	Date
_____		_____	
_____		_____	

Hospitalization History:

Cause:	Date	Cause:	Date
_____		_____	
_____		_____	

Patient's Name _____

PAST MEDICAL HISTORY
(Please **CIRCLE** if diagnosed or Currently have these conditions:

CONSTITUTIONAL:
Cancer: Type _____
ALLERGY IMMUNOLOGIC:
Allergies – Environmental
Angioedema (swelling of skin)
Hives
Recurrent infections – or rashes
Eczema
Food allergy _____
Reactions to stinging insects
Autoimmune disease _____
CARDIOVASCULAR:
Chest pain or discomfort
Irregular or fast heart beat
History of heart murmur
History of Rheumatic Fever
History of heart failure
Congenital heart disease
Heart attack
High blood pressure
High cholesterol level

ENDOCRINE:
Diabetes – Type I or Type II
Underactive thyroid
Overactive thyroid
Low blood sugar – Hypoglycemia

EYES:
Conjunctivitis – (pink eye)
Allergic – Bacterial
Glaucoma
GASTROINTESTINAL:
Celiac disease
GERD
Ulcers
Other food reactions _____
GENITOURINARY:
For females –
Pregnant or ? pregnant – Yes No
HEMATOLOGIC:
HIV/AIDS
Anemia
Hepatitis
HENT:
Headaches – Migraines
Otitis media – (ear infection)
Chronic sinusitis

MUSCULOSKELETAL:
Fibromyalgia
Arthritis – Osteo or Rheumatoid
Osteoporosis – Osteopenia
NEUROLOGICAL:
Seizures
Stroke – TIA
PSYCHIATRIC:
Depression
Anxiety
Bipolar Disorder
RESPIRATORY:
Bronchitis
Pneumonia
Asthma
Chronic cough
Shortness of breath
COPD – emphysema
Tuberculosis
Coughing up blood
Other unlisted medical conditions:

_____

_____

_____

FAMILY HISTORY: Must be completed for Immediate Family (Please circle all that apply)
A=Alive D=Deceased, YOB=year of birth. (If not known, please enter their age)

(**CIRCLE** any illnesses they have below – Please list up to 1 or 2 Siblings or Children – if None – leave blank)

Father	A or D	YOB _____	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Mother	A or D	YOB _____	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Sibling 1	A or D	YOB _____	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Sibling 2	A or D	YOB _____	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Child 1	A or D	YOB _____	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Child 2	A or D	YOB _____	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown

Siblings	# of brothers _____	# of sisters _____	Healthy – Yes	No
Children	# of sons _____	# of daughters_____	Healthy – Yes	No

Asthma/Allergy Family History: Please list family member(s) and allergic conditions: _____

Patient's Name _____

SOCIAL HISTORY:

Smoking: _____ Please circle if you are:

NEVER SMOKER current smoker former smoker vaping uses tobacco in other forms

Please circle form of tobacco: cigarette cigar pipe chewing tobacco snuff

Current/Past smoking history – please circle how many cigarettes you smoke – or did smoke per day:

1-9 cigarettes 10-19 cigarettes 20-39 cigarettes 40+ cigarettes per day chain smoker

If you stopped smoking - please answer the questions below:

How many years did you smoke _____

At what age did you start smoking _____ At what age did you stop smoking _____

Are you currently: (Please circle one) exposed to second hand smoke not exposed to second hand smoke

WORK ENVIRONMENT:

Occupation: _____

ENVIRONMENTAL HISTORY: (Please circle all that apply)

Pillow Contents:	Cotton	Feather	Foam	Non-allergenic	Polyester	Tempurpedic	
Mattress Contents:	Air	Feather	Foam	Spring	Tempurpedic	Water	
Comforter Contents	Feather	Cotton	Polyester				
Dust Mite Covers:	Pillow	Mattress	None Used				
Flooring in Bedroom:	Carpet	Area Rug	Wall-to-wall	Hardwood	Linoleum	Tile	Vinyl
Flooring in Home:	Carpet	Area Rug	Wall-to-wall	Hardwood	Linoleum	Tile	Vinyl
Pets:	None	Cat	Dog	Bird	Fish	Gerbil	
	Guinea Pig	Hamster	Mouse	Rabbit	Other _____		

Farm Animals: Please List: _____

Home Heated by:

Forced hot air by gas	Forced hot air by oil	Forced hot air by propane
Forced hot water by gas	Forced hot water by oil	Forced hot water by propane
Electric baseboard	Steam (radiator)	
Coal stove	Pellet stove	Wood stove

IMMUNIZATIONS:

Have you had a flu shot in the last year? Yes _____ No _____

If yes please give date (or approximate date) of flu shot: _____

Have you had a pneumonia shot in the last 5 years? (Pneumovax/Prevnar) Yes _____ No _____

If yes please give date (or approximate date) of pneumonia shot: _____

Have you been hospitalized in the last year? Yes _____ No _____

If yes please give date (or approximate date) of discharge. _____

Asthma &
Allergy
Physicians

Michael Lawrence, M.D.
Mark L. Claus, M.D.
Ralph Cohaly, M.D.
Darlene Madore, CPNP-PC
Carolyn Rooney, FNP-C
Gloria Iheuwa, FNP-BC

Allergy Testing Instructions

- Please arrive 15 minutes prior to your appointment time IF you have completed the Registration Form and the Medical History Questionnaire. IF you have not completed the forms, please arrive 30 minutes prior to your appointment to complete the forms here.
- We ask that you plan accordingly and be prepared to be in the office for approximately 2-2.5 hours.
- Wear a short sleeved shirt.
- Bring your Insurance card in with you the day of the visit.
- If your Insurance requires a referral, we must have it the day before your appointment.
- Bring your copay (if you have one) the day of the visit.
- If you are not able to keep this appointment, please call us as soon as possible.

"If you are sick with a fever, cough, chills or shortness of breath at the time of your scheduled appointment, please call the office to reschedule this appointment."

- Do not take Benadryl, Advil-PM, Excedrin-PM, Tylenol-PM or NyQuil 2 days prior to your appointment

- Do not take any other antihistamines for 5 days prior to the appointment

  Examples of antihistamines or meds that contain antihistamines are as follows:

  Alavert, Allergra, Atarax, Brompheniramine, Ceterizine, Chlorpheniramine, Chlor- Trimetron, Claritin, Clarinex, Desloratadine, Dimetane, Fexofenadine, Hydroxyzine, Levoceterizine, Loratadine, Tavist, Xyzal, Zyrtec

  Examples of nasal sprays are as follows:

  Astelin, Astepro, Dymista, Patanase, Olopatadine or Ryaltris

- If you are not sure whether you medications contain antihistamines, call the office or check with you Pharmacist.
- Instructions for LMX4/Lidocaine numbing cream is available for children under 14.

5/7/2025

35 Pearl Street, Suite 300
Brockton, MA 02301
(508) 584-6300
(508) 580-4664 (Fax)

675 Paramount Drive, Suite 303
Raynham, MA 02767
(508) 822-4100
(508) 823-9363 (Fax)

115 Water Street
Milford, MA 01757
(508) 634-8700
(508) 634-8311 (Fax)

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Dear Patient:

This appointment was scheduled for allergy skin testing. Please be prepared to be here approximately 2 to 2 ½ hours.
Upon arrival you will be brought into our testing area. One of our nurses will ask you questions regarding your symptoms, current medications an any previous treatment or allergic reactions. A medical assistant will administer the skin testing and pulmonary function test (if necessary). After the testing is completed, you will see one of our providers to discuss the results of the testing and they will recommend any treatment that might be indicated.

The following information is generalized and may or may not pertain to you specifically.

The charges for this visit will range from approximately $1,100.-$1,700. depending on the number of tests performed. The charges will be submitted to your insurance company. If your insurance requires a referral, **it must be in place prior to the visit**, if not the appointment will be rescheduled. If you have a co-payment we require it be paid the day of your visit.

We highly recommend you call your insurance company to check on any deductibles and or co-insurances prior to your visit with us. If you do not have any insurance coverage, we require payment in full on the day of the visit.

Upon check out, you will be given a ***Welcome Brochure*** and a copy of the patient appointment policy and our office hours. A copy of our Privacy Notice is available upon request.

If you have any further questions, you may ask the receptionist.

Sincerely,

Asthma & Allergy Physicians

35 Pearl Street, Suite 300
Brockton, MA 02301
(508) 584-6300
(508) 580-4664 (Fax)

675 Paramount Drive, Suite 303
Raynham, MA 02767
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115 Water Street
Milford, MA 01757
(508) 634-8700
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Asthma & Allergy Physicians

Patient Instruction/Consent Form for Allergy Skin Testing

Skin Test: Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read at 15 minutes after the application of the allergen. The skin test methods are:

Prick Method: The skin is pricked with a derma pick where a drop of allergen has already been placed.

Intradermal Method: This method consists of injecting small amounts of an allergen into the superficial layers of the skin. We do not do intradermal testing for food allergy.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

You will be tested to important airborne allergens in our area and/or foods. These include, trees, grasses, weeds, molds, dust mites, and animal danders. If you are having food skin testing this will be tailored to your needs or a general panel will be performed. The skin testing generally takes 45 minutes. Prick (also known as percutaneous) tests are usually performed on your lower arms. Intradermal skin tests may be performed if the prick skin tests are negative and are performed on your upper arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit. You may be scheduled for skin testing to antibiotics, anesthetics, venoms, or other biological agents. The same guidelines apply.

Skin testing will be administered at this medical facility with a medical physician or other health care professional present since reactions may require immediate therapy. Reactions to allergy testing are rare. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the physician and nurse know if you are pregnant or taking beta- blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reaction to the allergy testing. Beta-blockers are medications that may make the treatment of the reaction to skin testing more difficult. Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available. After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment.

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient Name _____ Signature_____ Date signed _____

Parent or legal guardian* _____ Date signed _____

Witness _____ Date signed _____

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