

Patient's Name _____ Age _____ Date of Birth _____ Male/Female Today's Date _____

Do you wear Latex Gloves Daily? _____ Do you use Latex Products Daily? _____ How many Surgeries have you had? Total _____

Do you have Eczema or other Rashes on your hands? ___ If yes, explain _____

Have you had itching, swelling, or other symptoms following dental, rectal or pelvic exams? _____

Have you experienced swelling or difficulty breathing after blowing up a balloon? _____

Do condoms, diaphragms, or Latex sexual aids cause itching or swelling? _____

Do rubber handles, rubber bands, or elastic bands on clothing cause any discomfort? _____

Do any of the Foods listed below cause Hives, itching of the lips or throat, or any more severe symptoms after handling/ingestions?

Apple	Apricot	Avocado	Banana	Carrot	Celery	Passion Fruit
Grape	Hazelnut	Kiwi	Melon	Nectarine	Papaya	Fig
Pear	Pineapple	Plum	Potatoes	Tomatoes	Chestnut	Peach

Marital Status _____ Education Status _____ Occupation _____ Employer _____

Occupational Exposure _____ Recent Travel _____

Hobbies (Indoor/Outdoor) _____

Do you Smoke? _____ (Cigarettes, Cigar, Pipe, Other) _____ # per day How long _____ Years

Have you considered quitting? _____ When did you quit? _____ Are you exposed to others smoking? _____ Estimated Quit Date _____

Do you drink Alcoholic Beverages? _____ If yes, how many per week? _____ What type _____ Do you get Congested? _____

Do you use illegal drugs? _____ If yes, please explain _____

FAMILY HISTORY

<i>Living/Deceased</i>	<i>Age</i>	<i>Medical Conditions/Cause of Death</i>	<i>Living/Deceased</i>	<i>Age</i>	<i>Medical Conditions/Cause of Death</i>
Mother _____			Father _____		
Mat Grandmother _____			Pat Grandmother _____		
Mat Grandfather _____			Pat Grandfather _____		
Aunt/Uncle _____			Aunt/Uncle _____		
Sibling/Child _____					

ENVIROMENTAL HX

Location of where you live? City Suburb Country/Farm Seashore Other

Do you live in a (style): Home Condo Apartment Dorm Other

Number of Floors _____ Age of Residence _____ Length of Occupancy _____ months/years

Heat: Oil Gas Electric Baseboard Radiators Forced Air Other

Air Conditioning: Central Window Other None

Humidifier: Central Separate Units Other None **Air Filtration:** Yes No Frequency Changed: _____

Basement: Damp Musty Seepage/Flooding None

Do you have pets? _____ If yes, described _____ How Many _____ How long exposed _____

Are Pets allowed in your bedroom? _____ What kind of Pets have you had previously? _____

Please indicate contents of furnishings in your environment (stuffed, feathers, foam, wool, tile, linoleum, cotton, and synthetic, other, unknown)

Flooring/Padding: Living Room _____ Bedroom _____ Basement _____

Bedroom: Sleeps Alone Shares Other

How often do you change your bed linens? _____ What Water Temperature are your linens washed? _____

Box Spring/Mattress _____ Waterbed _____ Other _____

Pillows _____ Comforter _____ Linens _____

Allergy control Encasements on: Box Spring ___ Mattress ___ Pillows ___ Comforter ___

Window Treatments: Curtains _____ Blinds _____ Shades _____ Other _____ None _____

Have you had any new Environmental changes, books, trophies, stuffed animals, games, collections at: Home _____ School _____ Work _____

LPN/RN _____

MD _____

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Primary Care Physician _____ Referred By: _____ Pharmacy Name: _____ Mail Order/Local _____

In your own words please describe your symptoms/problems you wish to be discussed today. **Please include when it began, how often, when is it worse day/night, how long it lasts. What makes it better, what makes it worse?** Do your symptoms interfere with your activities, are you ever symptom free?

Circle months affected: January February March April May June July August September October November December ALL YEAR

How many colds do you have each year? 1-2 3-5 6-12 more than 12

Have you ever been evaluated by an Allergist? _____ If yes, Name _____ and when _____

Have you ever had Allergy Skin Testing? _____ If yes, when _____ Have you ever received Allergy Injections? _____ How long _____

Have you ever had Cortisone injections? _____ If yes, when and for what _____

Has there been difficulty sleeping at night due to the symptoms of Allergy? _____

Please List **ALL Medications (PRESCRIBED and OVER THE COUNTER)** that you are taking at the present time and the reason for taking them

Medication	Dosage	How many times per day	Last Dose	Reason for taking
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Do you have Allergies to Medications or Foods?

Do any of the following cause or make your symptoms worse. Please circle what you have noticed to bother you or make your symptoms worse.

- | | | | | | |
|-------------|-----------------------|-------------------|---------------------|------------|-------------------|
| Foods | Indoor heat in winter | Hair spray | Insect Spray | Dust | Guinea Pig/Gerbil |
| Perfume | Cigarette Smoke | Feathers/Pillows | Zoo | Powder | Raking Leaves |
| Cats | Odors | Change of Seasons | Newspapers | Tooth Pain | Rubber |
| Birds | Change in Weather | Paint Lacquer | Excitement/Emotions | Mice | Horses |
| Paint Fumes | Exertion (running) | Farms | Rabbit | Wax | Cold Air |
| Mold/Mildew | Dog | Glue | Dampness | Circus | Cleanser |
| Grass | House Plants | Soap | Weeds | Hamsters | Barn Hay |

Last Eye Exam _____	Last Physical Exam _____	Last Dental Exam _____		
(Doctor) _____	(Doctor) _____	(Dentist) _____		
Last PAP Smear _____	Last Mammogram _____	First Date Last Menses _____	Length/flow _____	Menopause _____

LPN/RN _____

MD _____

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Please circle any below that you have or have had in the past.

Hay Fever	Asthma	Dryness of Skin	Heart Disease
Runny Nose	Wheezing	Eczema/Dermatitis	Hypertension
Itching of the ears	Coughing	Swelling from Insect Bites	Heart Murmur
Sinus Headaches	Shortness of Breath	Reaction Soap/Detergent	Rheumatic Fever
Sinus Infections	Hospitalization/Asthma	Reaction Nickel/Metals	Scarlet Fever
Ear Infection (R/L)	Emergency Visits/Asthma	Penicillin Allergy	Irregular Heart Rate
Itching of the roof of mouth	Bronchitis	Sulfa Allergy	Pacemaker
Sinus Problems	Tingling Hands/Feet	Other Drug Allergy	Kidney Stones/Disease
Ear Fullness/Popping	Freq Awakening 2am-6am	Reaction Poison Oak/Ivy	Testicular Masses/Cancer
Ear Drainage (R/L)	Croup	Reaction to Latex	BPH (Benign Prostate Hypertrophy)
Post Nasal Drip	Pneumonia	Glaucoma (R/L)	Bowel Habit Changes
Sneezing	Voice Changes	Double Vision	Hemorrhoids
Red Itchy/Watery Eyes	Pleurisy	Cataracts (R/L)	Jaundice
Ringing in the Ears (R/L)	Tuberculosis	Color Blindness	Diarrhea
Nose Bleeds	Hives	Breast Lumps (R/L)	Hepatitis
Tonsillitis	Swelling of the Face	Abnormal PAP Smear	HIV positive/AIDS
Smelling Impairment	Swelling of the Lips	Cancer (Type)	Mouth Sores
Loss of Hearing (R/L)	Persistent Coughing	Thyroid under/over active	Liver Disease
Nasal Discharge	Life Threatening Reaction	Lupus	Alcoholism
Lightheadedness/Vertigo	Food Allergy	Easy Bruising	Bleeding Disorder
Stroke (CVA)	Throat Tightness	Ulcer	Fevers
Difficulty Swallowing	Intubation	Arthritis	Urinary Incontinence
Dizziness/pass out	Hoarseness	Joint Pain	Unexplained Fevers
Changes in Appetite/Weight	Cold Extremities	Twitching	Phlebitis
Migraine Headaches	Bulimia/Anorexia	Sleep Disturbances	Skin Color Changes
Epilepsy/Seizures	Hair Loss	Loss of Consciousness	Intolerance to Cold
Polio	Chemical Dependency	Psychiatric Care	Loss of Strength
Fatigue/Weakness	Depression	Anxiety	Fractures/Trauma
Diabetes	Scleroderma	Palpitations	

Past Surgeries: _____

LPN/RN _____

MD _____

INFORMATION FORM

Patient _____ Male / Female Birth Date _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____
Marital Status (S M D W O) Student _____ F P Spouse _____ Spouse's DOB _____
Social Security _____ Driver's License _____
Employer _____ Full / Part Time Years Employed _____
Address _____ Town _____ State _____ Zip _____
Primary Care Physician _____

PERSON RESPONSIBLE FOR ACCOUNT (If patient is a minor please complete next section)

Mother's Name _____ Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Employer _____ Status _____ Years of Employment _____
Social Security Number _____
Father's Name _____ Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Employer _____ Status _____ Years of Employment _____
Social Security Number _____

INSURANCE INFORMATION

Primary Carrier _____ Policy # _____ Group # _____
Sponsor/Employer _____ Referral Y / N Effective Date _____ Copay \$ _____
Secondary Carrier _____ Policy # _____ Group # _____
Sponsor/Employer _____ Referral Y / N Effective Date _____ Copay \$ _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relationship _____ Phone (Home) _____ - (Cell) _____

WHO SHOULD WE THANK FOR THIS REFERRAL?

NAME _____

Financially Responsible

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and cost of collection in the event of default. Payments including: co-payments are expected at the time of service, for new evaluation, Office visits, and Allergy injections. Accounts with balances over 30 days will be subject to 1% monthly (12% APR) late payment charges. It is the patient's responsibility to obtain a valid referral if required by your HMO carrier. Services rendered without such valid referral will be the patient's responsibility.

I have read and fully understand the policies and procedures of this office.

Signature _____

Date _____

Adult & Pediatric Allergy & Asthma of CT

KEVIN P. MCGRATH, M.D.
912 SILAS DEANE HIGHWAY, SUITE 100
WETHERSFIELD, CT 06109
(860) 257-3535
(860) 257-0551 FAX

Patient Name _____ Date of Birth _____ SS# _____

SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions.

I authorize the release of any medical or other information necessary to process claims. I also request payment of Government benefits to myself or to Kevin P. McGrath, M.D., who accepts assignment.

I understand that I am responsible for my bill.

I understand that it is my responsibility to obtain any referrals that my health plan may require. If I fail to obtain such referral, I will be responsible for payments to Kevin P. McGrath, M.D.

I authorize my doctor to act as an agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

It is the office policy of Adult and Pediatric Allergy and Asthma of CT not to release confidential medical information regarding your treatment to family members or friends, except:

Parent/legal guardian

Other persons authorized in writing by patient

As we may responsibly infer from our records

If you anticipate that you will need or want your medical information provided to family, friends. Etc., please indicate below so we may best serve you.

By signing below, you authorize full release: Medical Information

Spouse _____ yes no

Parent _____ yes no

Other _____ yes no

You are also entitled to alternative, reasonable means of communication, if you do not wish to be contacted in a certain way.

Signature _____ Date _____

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

“I hereby acknowledge that I have received a copy of this practice’s NOTICE OF PRIVACY PRACTICES. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient Signature (of Patient Representative) _____ Date _____

FOR OFFICE USE ONLY

TO BE COMPLETED BY THE PRACTICE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT

- Patient refused or declined to sign request to sign written acknowledgement
- Patient could not understand request to sign written acknowledgement
- Other reason (please specify)

Employee Signature _____ Title _____ Date _____

Kevin P. McGrath, M. D., F. A. C. A. I.
Adult and Pediatric Allergy and Asthma
912 Silas Deane Hwy.,#100
Wethersfield, CT 06109
(860) 257-3535

PHOTOGRAPH CONSENT

I, _____, give Dr. McGrath and his
staff permission to use my picture for the purpose of patient
identification.

Signed: _____

Date: _____