

PRINT and sign these forms.
Bring them to your appointment or fax to 703-478-6612

PATIENT REGISTRATION

Patient Last Name: _____ First Name: _____ Medical Record#: _____
Sex: F M Date of Birth: _____ Age: _____ Social Security #: _____
Address: _____ City: _____ State: __ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell (Opt.): _____
Marital Status: S M D W Employer Name: _____
Referred by: _____ Personal Physician: _____

FOR CHILDREN UNDER THE AGE OF 18: In the case of an emergency, and I cannot be contacted, I give my permission to the doctors or the persons under their instruction to treat my child in their office or hospital as required by the events or that emergency situation.

Parent's Signature: _____

GUARANTOR (RESPONSIBLE PARTY) INFORMATION

Name: _____ Relationship to Patient: _____
Sex: F M Date of Birth: _____ Age: _____ Social Security #: _____
Address: _____ City: _____ State: __ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell (Opt.): _____
Employer Name: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ ID#: _____ Group #: _____
Address: _____ City: _____ State: __ Zip Code: __ Phone #: _____
Subscriber Name: _____ Employer: _____ Social Security #: _____
Effective Date: _____ Subscriber Birthdate: _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ ID#: _____ Group #: _____
Address: _____ City: _____ State: __ Zip Code: __ Phone #: _____
Subscriber Name: _____ Employer: _____ Social Security #: _____
Effective Date: _____ Subscriber Birthdate: _____ Relationship to Patient: _____

MEDICAL RELEASE AUTHORIZATION

I AUTHORIZE THE Adult and Pediatric Allergy Center of Northern Virginia to apply for benefits on my behalf for covered services rendered. I request payment be made directly to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. I understand I will be responsible for all charges made for services as well as all costs of collections and reasonable attorney fees (minimum \$15) if this account is placed in the hands of an attorney.

Signature

Date

AT THIS TIME BELOW IS A LIST OF INSURANCE COMPANIES THAT WE PARTICIPATE WITH:

AETNA CHOICE POS II	AETNA HEALTHFUND
AETNA OPEN ACCESS ELECT CHOICE EPO	AETNA OPEN ACCESS MANAGED CHOICE
AETNA OPEN CHOICE PPO	AETNA TRADITIONAL CHOICE INDEMNITY
ALLIANCE PPO	ANTHEM BC/BS PPO
ANTHEM BC/BS FEDERAL EMPLOYEE	ANTHEM BC/BS TRIGON PPO
CCN PPO	CIGNA PPO
COVENTRY	CIGNA OPEN ACCESS
FIRST HEALTH PPO	GEHA PPO
GREAT WEST PPO	HUMANA PPO
MAMSI HEALTH AND LIFE PPO	MULTIPLAN PPO
NCPPO	ONE HEALTH PPO
PHCS PPO	ONE NET
PRINCIPAL PPO	NALC
UNITED HEALTHCARE PPO	UNICARE PPO
UNITED HEALTHCARE SELECT AND SELECT PLUS (POS AND EPO)	

THE FOLLOWING ARE A LIST OF HMO'S OR MANAGED CARE COMPANIES WE PARTICIPATE WITH:

AETNA ELECT CHOICE EPO	AETNA MANAGED CARE POS
BC/BS CAPITAL CARE OR BLUE CHOICE HMO	CIGNA HMO
HEALTHKEEPERS HMO	OPTIMUM CHOICE
ANTHEM HMO	
UNITED HEALTHCARE CHOICE AND CHOICE PLUS HMO	

IF YOU ARE MEMBER OF ONE OF THE ABOVE HMO PLANS IT IS **YOUR RESPONSIBILITY** TO HAVE AN UP TO DATE AND ACCURATE REFERRAL AT THE TIME OF YOUR APPOINTMENT. IF YOU HAVE NOT OBTAINED A REFERRAL, IT IS EXPIRED, OR DID NOT BRING IT WITH YOU; YOU WILL BE RESPONSIBLE FOR ALL CHARGES.

WE DO NOT GUARANTEE PARTICIPATION, BENEFITS, OR COVERAGE WITH INSURANCE COMPANIES. IT IS THE PATIENT'S/PARENT'S RESPONSIBILITY TO CONFIRM OUR PARTICIPATION AND BENEFITS WITH THEIR INSURANCE COMPANY.

WE SUGGEST THAT YOU CALL THE PHONE NUMBER ON THE BACK OF YOUR INSURANCE CARD TO CONFIRM OUR PARTICIPATION AND YOUR BENEFITS PRIOR TO YOUR APPOINTMENT.

IF YOU PARTICIPATE WITH AN INSURANCE COMPANY NOT LISTED ABOVE WE WILL FILE YOUR CLAIM AS A COURTESY. HOWEVER, YOU MUST PAY AT THE TIME OF YOUR VISIT. IF YOU DO NOT HAVE AN INSURANCE CARD WITH YOU, YOU WILL NEED TO PAY FOR YOUR VISIT IN FULL.

SIGNATURE

DATE

HEALTH HISTORY

Name _____ Age _____ Today's Date _____
Birth Date _____ Date of last physical examination _____ Primary Care Dr. _____

I. Check the problem(s) which bring you to our office:

- Anaphylaxis (shock) Asthma Ear problems Eczema Eye problems Food Allergy
- Hives Polyps Rhinitis ("Hay fever") Serum sickness Sinusitis (sinus infections)
- Stinging Insect Allergy Swelling Other _____

II. MEDICATIONS (List medications you are currently taking, including all over the counter and supplements): _____

III. ALLERGIES (To medications or substances): _____

IV. SYMPTOMS (Check symptoms you currently have or have had in the past year):

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Nervousness
- Numbness
- Sweats
- Weight loss

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

GASTROINTESTINAL

- Appetite poor
- Bloating
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

WOMEN ONLY

Are you pregnant? Yes No

EYE/ EAR/ NOSE/ THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – flashes
- Vision – halos

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulder

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

V. CONDITIONS (Check conditions you have or have had in the past):

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Ear infections
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High blood pressure
- High cholesterol
- HIV positive
- Hives
- Kidney disease
- Liver disease
- Lupus
- Measles
- Migraine headaches
- Miscarriage
- Mononucleosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate problem
- Psychiatric care
- Recurrent upper respiratory tract infections
- Recurrent sinus infections
- Rheumatic fever
- Scarlet fever
- Skin rashes
- Stroke
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Typhoid fever
- Ulcers
- Vaginal infections
- Venereal disease

VI. FAMILY HISTORY

Fill in health information about your family:

Relation	Age	State of health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relative had any of the following: Disease Relationship to you	
<input type="checkbox"/>	Asthma, hay fever
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Chemical dependency
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Lupus/Rheumatoid Arthritis
<input type="checkbox"/>	Pulmonary (lung) Disease
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Other
<input type="checkbox"/>	

VII. HOSPITALIZATIONS/SURGERIES

Year	Reason for hospitalization or surgery

VIII. PATIENT SOCIAL HISTORY:

- Marital status: Single Married Separated Divorced Widowed
- Use of alcohol: Never Rarely Moderate Daily
- Use of tobacco: Never Previously, but quit Current, packs/day _____
- Use of drugs: Never Type/ Frequency _____
- Excessive exposure at home, work or school to: Fumes Dust Solvents Airborne particles Smoke
- Your occupation: _____

IX. ENVIRONMENTAL HISTORY:

- Age of your home: _____ How long have you lived there? _____
- Your home is a(n): Apartment Townhouse Detached home
- Heat at home is (check all that apply): Forced warm air (central heating) Radiator (steam/hot water)
 Electric baseboard Wood stove
- Air conditioning at home: None Central Window units _____ Bedroom _____ Living room/family room
- Humidifier at home: None Central (furnace) Room unit, location _____
- Air cleaner/purifier at home: None Central (furnace) Room unit, location _____
- Type of mattress on the patient's bed: Regular Air mattress Waterbed Other _____
Age of mattress _____
- Dust mite covers? Yes No If yes, they are on Mattress Box Springs Pillows Comforters
- Type of pillow on the patient's bed: Foam/ fiber-filled Feather Other _____
Age of pillow _____
- Type of comforter on the patient's bed: Down-filled Polyester fill Cotton fill Other
- Carpeting: In the home: Wall to wall Area rug None
 Patient's bedroom: Wall to wall Area rug None
- What fur-bearing pets do you have? None Cat(s) Dog(s) Other _____
- Do you have feathered pets? No Yes
- Do these pets have access to the patient's bedroom? Never Sometimes Often

Patient Information

What is an Allergist?

An allergist is a specialist who has had training in internal medicine or pediatrics and subsequently special training in the field of allergy and immunology, which diagnoses and treats allergic diseases. These diseases include seasonal and/or year-round nasal or eye symptoms, nasal polyps, asthma, hives, food allergies, insect sting allergy and certain drug allergies.

Your physicians in this office are certified allergy specialists, Diplomates of the American Board of Allergy and Immunology (a co-join board of Internal Medicine and the American Board of Pediatrics) as well as fellows of the American Academy of Allergy and Immunology.

Will I still need a Family Physician?

Because we are specialists, we do not provide primary care. If you do not already have a primary care physician, we will be glad to assist you in finding one. Routine physicals, non-allergic problems, acute infections and emergencies should be referred to your primary physician. We will send a report on your allergy evaluation to your referring physician. We will provide continuing outpatient care of your allergy problems.

Insurance

It is your responsibility as a patient to understand the terms of your insurance policy. This includes obtaining a valid referral before services can be rendered by this office. The patient is responsible for any charges not covered by their insurance policy including co-pays and deductibles, or if a valid referral was not obtained.

Appointments

Patients are seen by appointment Monday through Friday. The office is open Monday 9:00 a.m. to 5:30 p.m., Tuesday through Thursday 9:00 a.m. to 6:00 p.m., and Friday 9:00 a.m. to 4:00 p.m. Call (703) 689-2000 to make an appointment. Please call several months prior to when the appointment should be scheduled.

Cancellations

If you are unable to keep an appointment, please call the office as soon as possible. We request that cancellations be made at least 24 hours in advance as this allows us to give you and all our patients' better service. If the office is closed, please call the answering service at (703) 755-1590. Appointments not cancelled within 24 hours will result in charge of \$25.00.

Prescription Refills

We will be glad to refill routine prescriptions during our regular office hours. Just have your pharmacist fax us a request. Office policy is that patients are required to have been seen within the past year in order to have a prescription refilled.

Telephone Calls

Please feel free to call during office hours if you have any questions regarding your condition, medications or therapy. If our medical assistants are unable to answer your questions, then a physician will return your call. If you have an emergency, the primary doctor should be notified first. If an admission to the hospital is necessary, this can be done by your family physician. We will be glad to consult with him or her concerning any allergic factors at his or her request.

Signature of Patient/Parent if Minor

Date