

No antihistamines 48 hours prior to visit, unless hives are present.

ZIV HARISH, M.D., FAAAAI, FACAAI
200 Engle Street, Suite 18, Englewood, NJ 07631
(201) 871-7475

Appointment Date: _____

Time: _____

Last Name: _____ First Name/Mi: _____
Street: _____ City/State: _____ Zip: _____
Phone # (____) _____ Social Security #: _____ - _____ - _____
Sex: M ____ F ____ Date of Birth: _____ Married _____ Single _____ Other _____
Employed? Yes ____ No ____ Full-time Student? Yes ____ No ____ Part-time Student? Yes ____ No ____

Who Is Responsible for patient bills? (Fill in only if other than patient)

Spouse _____ Parent _____ Other _____

Mr. ____ Mrs. ____ Miss ____ Ms. ____

Last Name: _____ First Name/Mi: _____
Street: _____ City/State: _____ Zip: _____
Phone # (____) _____ Social Security #: _____ - _____ - _____
Cell Phone # (____) _____ Date of Birth: ____/____/____
Employer: _____ Email: _____
Street: _____ City/State: _____ Zip: _____
Work Phone # (____) _____ Ext: _____

I will be paying today by: Cash ____ Check ____ Credit Card ____ * Please make checks payable to Ziv Harish, M.D., P.C.

Who referred you to us? _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Policy No.: _____ Group No.: _____

Street: _____ City/State: _____ Zip: _____

Phone # (____) _____ Co-payment: Yes ____ No ____ \$ _____

Subscriber (if other than patient): Spouse _____ Parent _____ Other _____

Last Name: _____ First Name/Mi: _____

Street: _____ City/State: _____ Zip: _____

Phone # (____) _____ Social Security #: _____ - _____ - _____

Sex: M ____ F ____ Date of Birth: _____

Employer: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Policy No.: _____ Group No.: _____

Street: _____ City/State: _____ Zip: _____

Phone # (____) _____ Subscriber (if other than patient): Spouse _____ Parent _____ Other _____

Last Name: _____ First Name/Mi: _____

Street: _____ City/State: _____ Zip: _____

Sex: M ____ F ____ Birthday: _____ Social Security #: _____ - _____ - _____

Employer: _____

** Does your insurance company have any restrictions regarding services such as lab work, X-rays or laboratories we may use? Please Explain:

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to Dr. Harish as agreed upon at the time of treatment for services rendered. I assume responsibility for payment of my account.

Signature: _____ Date: _____

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AN IMPORTANT MESSAGE TO OUR PATIENTS ABOUT YOUR INSURANCE COVERAGE

***** PROTECT YOUR INSURANCE BENEFITS *****

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know or keep up to date with each program's provisions.

- Some programs require that a specific laboratory be used, while other programs may require that a different laboratory be used.
- Some programs require a REFERRAL form that must be brought with you at the time of your visit. If it is not brought, you will be responsible to pay for the visit.
- Some programs do not cover certain procedures; i.e., flu-shot is considered preventative care and is not covered by some programs.
- Some programs require authorization for MRI, CT scans, and RAST testing.
- Some programs require pre-authorization while others do not.
- Some insurance companies require that PATIENTS notify them when they are admitted to the hospital.
- Some programs have strict length of stay limits for HOSPITALIZATION.
- Some programs have other restrictions.

It must be your responsibility to know and advise us of your program's requirements in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

Please understand that if we have not been advised in advance of your program's requirements or conditions and we provide a service, or use a laboratory that is outside of the program, you will be responsible for the appropriate fees.

Your insurance carrier should provide you with a phone number for you to use if you have a question about your coverage. However, do not hesitate to ask for help in this matter.

Please note that we reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

I have read the above statement regarding my responsibilities toward my insurance carrier and agree that I am ultimately responsible for any fees which my carrier will not pay due to my failure to comply with their regulations, or fees that will be charged due to appointments that were cancelled or broken without 24 hours advance notice.

Patient's printed name

Signature of patient or legal guardian (if patient is under 18 years of age)

Date

ALLERGY QUESTIONNAIRE

Patient's Name	Date of Birth	Date of Appointment
Primary/Referring Physician	City/State	Tel. #:

1. INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem. Bring this completed form for our first appointment.

Briefly describe the reason for your allergy visit and what you hope to accomplish: _____

2. PROBLEMS: Have you ever had the following conditions?

Yes	No	(check all items)	Age at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma (wheezing)					
		Any other breathing problems					
		Sinus trouble					
		Allergic rhinitis (hay fever – runny, stuffy, itchy nose; sneezing)					
		Hives or swelling					
		Eczema or other rashes					
		Frequent infections					
		Food reactions					
		Drug reactions					
		Insect reactions					

3. SYMPTOMS: Have you ever had any of the following? If not, leave blank.

	How many days in the last month?	Severity			Circle the months most severe
		Mild	Mod.	Sev.	
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 with 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

4. FOOD REACTIONS: Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid? If yes, specify below.

Food	Approximate Date	Symptoms	Can food be eaten?		Date food was last eaten
			Yes	No	

5. PRECIPITATING FACTORS/TRIGGERS: For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers:

	Condition			Condition		
	Made Worse	No Change		Made Worse	No Change	
Cutting or playing in grass, raking leaves	<input type="checkbox"/>	<input type="checkbox"/>	Paint, lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	
Weather changes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Moldy, mildewed areas or items (basement, attic, etc.)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Sweeping, dusting or vacuuming	<input type="checkbox"/>	<input type="checkbox"/>		Tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>
Smog, smoking or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>		Other strong odors	<input type="checkbox"/>	<input type="checkbox"/>
Cat	<input type="checkbox"/>	<input type="checkbox"/>		Specify _____		
Dog	<input type="checkbox"/>	<input type="checkbox"/>		"Colds" or viruses	<input type="checkbox"/>	<input type="checkbox"/>
Other animals	<input type="checkbox"/>	<input type="checkbox"/>		Physical exertions or exercise,	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>		Specify _____		
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify _____	<input type="checkbox"/>	<input type="checkbox"/>		Cold weather	<input type="checkbox"/>	<input type="checkbox"/>
			Specify _____			

6. RELIEVING FACTORS: Please indicate whether you (or your child's) condition is affected by the following medications.

MEDICATIONS:	Condition			MEDICATIONS:	Condition		
	Made Worse	Condition Improved	No Change		Made Worse	Condition Improved	No Change
Asthma medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decongestants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____			
Nose drops or sprays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

7. RESIDENCE: List your past residences with your most recent first. Only City and State required.

City & State	Effect on symptoms (better, worse, no change)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

8. PREVIOUS ALLERGY EVALUATION AND THERAPY:

Have you ever had allergy skin tests?
 Yes No If yes, date _____ Physician's Name _____
 Results of these tests: (If possible please provide us with copy)

Have you ever had allergy injections?
 Yes No If yes, give dates _____

9. OTHER MEDICAL PROBLEMS: Have you ever had any of the following? Answer all items.								
Check all items	Yes	No		Yes	No		Yes	No
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble (e.g. Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Nasal polyps	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>
Operation on sinuses	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
Sinus X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Poison ivy or poison oak	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Colic or spitting up as an infant	<input type="checkbox"/>	<input type="checkbox"/>	Croup	<input type="checkbox"/>	<input type="checkbox"/>
Number past year _____			Frequent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Bronchiolitis (under age 2)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Tonsils/Adenoids removed (date) _____			indicate type if known _____					
Pneumonia, number past year _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>			

10. BIRTH HISTORY: Please fill for children under age 7 or if abnormal.	
Length of pregnancy: term _____ premature _____	Breast feeding: Yes _____ No _____ Length _____
If premature, how many weeks? _____	Formulas used: Name _____
Mode of delivery: vaginal _____ c-section _____	If formula was changed – explain why? _____
Complications requiring intensive care: Yes _____ No _____	_____
If yes; was respiratory assistance required? Yes _____ No _____	_____
Birth weight: _____ lb _____ oz.	_____

11. IMMUNIZATIONS: Please fill for children under age 5 or if patient suffers from recurrent infections (list dates and reactions, if any)	
Polio _____	Hepatitis _____
DPT _____	Varicella _____
Tetanus booster _____	Pneumococcal (Pneumovax/Prevnar) _____
MMR _____	_____
HIB _____	Other _____

12. HOSPITALIZATIONS:		
List most recent first:	Reason	Date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

13. SURGERY:		
List most recent first:	Reason	Date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

14. FAMILY HISTORY:

Do any members of your family have a history of allergies or related diseases?

Yes No If yes, list all relatives (e.g., parents, brothers & sisters, children, aunts, uncles, grandparents, etc.)

Asthma			
Hay fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia/Sinusitis			
Headaches			
Allergy to pets			
Insect venom allergy			
Food allergy			

Other allergies

Is there a family history of any other illnesses?

Yes No If yes, list all relatives.

Emphysema or other Lung Disease			
Cystic Fibrosis			
Tuberculosis			
Thyroid disease			
Glaucoma			
Diabetes			
Cancer			
Hypertension			
Heart disease			
Other			

15. ENVIRONMENTAL SURVEY:

Where do you live? House _____ Appt _____ Floor _____	Number of indoor plants
Age of house: _____ years How many years in current location? _____	Do you have: (a) an air cleaner? (b) an air dehumidifier? (c) an air humidifier?
Are any rooms damp or musty?	Type of air conditioning (central, window, ceiling fan, etc):
Type of heating (forced air, steam, space heater, baseboard, electric, etc.):	
Type of carpet: _____ Bedrooms _____ Living room _____ Den _____ Dining room _____ Basement _____ Please specify if known (wool, synthetic) Type of pad: (please specify if known)	
How old is your pillow? _____ Comforter? _____ Mattress? _____	Is your mattress: <input type="checkbox"/> foam rubber <input type="checkbox"/> cotton
Is your pillow: <input type="checkbox"/> feather/down <input type="checkbox"/> foam rubber <input type="checkbox"/> encased in plastic/ vinyl/ dust mite protective cover <input type="checkbox"/> kapok? <input type="checkbox"/> other	<input type="checkbox"/> innerspring & cotton <input type="checkbox"/> waterbed <input type="checkbox"/> encased in plastic <input type="checkbox"/> other _____
Is your comforter: <input type="checkbox"/> synthetic <input type="checkbox"/> feather / down	Do you have any stuffed furniture? <input type="checkbox"/> upholstered <input type="checkbox"/> leatherlike
Do you have pets? List number and kind (dog, cat, birds, horses, etc.)	Do your pets spend time indoors? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have exposure to pets or pet owners at school/work? Specify type:	
What type of work do you do?	
Are you exposed to anything at work that might aggravate your condition? Which things?	
Have you missed any time from work or school because of allergies? How much time?	
Do you have any other allergen exposures from hobbies, recreations, activities, etc.?	

16. CURRENT MEDICATIONS: Please list all the medications that you are currently taking, including dose and times

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

17. RECENT MEDICATIONS: Please list all the medications that you have taken in the last year
(include over the counter medications)

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

18. SMOKING:

Have you ever smoked? Yes _____ No _____
If yes, how many years? _____
Do you presently smoke? _____
When did you stop? _____
Average cigarettes at highest point? _____

If you still smoke, do you think you could stop? _____
Which other family members now smoke? _____

19. PASSIVE SMOKE:

Is patient exposed at home or at work to smoke?
(cigar/cigarettes)

Yes No