SHORELINE ALLERGY & ASTHMA ASSOCIATES, LLP

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23 CLARA DRIVE.
MYSTIC, CT 06355
860-536-2995

BILLING DEPT: 860-536-8375

314 FLANDERS ROAD.
EAST LYME, CT 06333
860-739-3011

We at Shoreline Allergy and Asthma Associates, LLP want to give our patients the best possible care that we can offer. When in our office you deserve our undivided attention and the maximum time you have scheduled for your appointment.

We understand that emergencies arise which can cause you to run late or not be able to make the appointment at all. If this should occur, please call the office so that we can reschedule or advise you accordingly. If you are more than 15 minutes late for your appointment you may need to reschedule. Repeated cancellations or missed appointments will result in loss of future appointment privileges. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

We would appreciate you making every effort to arrive 15 minutes prior to your scheduled appointment, so that you will receive the attention you deserve.

PLEASE TAKE A MOMENT TO COMPLETE THE ENCLOSED FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT ON:

_____@_____am/pm IN THE _____ OFFICE WITH DR._____ so the completion of the paperwork will not interfere with your scheduled time or the quality of your visit.

Treatment of a Minor: **Due to the in-depth history and exam for New Patients, a parent or legal guardian MUST accompany any patient under the age of 18. No Exceptions.**

Thanking you in advance for your attention in this matter.

Please feel free to visit our patient portal prior to your appointment
https://shoreline-allergy.portalforpatients.com

If you do not speak or understand English, please bring a translator with you to your appointment.
(Si no hablan o entienden a inglés, por favor, traer un traductor con usted a su cita.)

NOTE:

DUE TO THE NATURE OF OUR PATIENTS SENSITIVITIES:

Shoreline Allergy and Asthma Associates

IS A FRAGRANCE FREE ENVIROMENT

NO FOOD OR DRINK ARE ALLOWED IN PATIENT AREAS

TO RESPECT ALL PATIENTS IN THE OFFICE, PLEASE REFRAIN FROM USE OF CELL PHONE

THANK YOU.

SHORELINE ALLERGY AND ASTHMA ASSOCIATES

MYSTIC DIRECTIONS-23 Clara Drive-phone: 860-536-2995

From 95 going North (from the Groton/New London area)

Take Exit 90 (Mystic Aquarium/Mystic Seaport Exit), Go straight through light at the end of exit ramp. Follow brown signs to Mystic Aquarium parking. Bear right towards Mystic Aquarium. Drive past Aquarium, on your left, to stop light. Go straight across intersection. Office building will be on your 1st left after the Hilton. Entrance is located in the back of the building. Thru doors with green awning.

From 95 going South (from Rhode Island)

Take Exit 90 (Mystic Aquarium/Mystic Seaport Exit), Go left at the end of exit ramp. Take next left, follow brown signs to Aquarium parking. Bear right towards Mystic Aquarium. Drive past Aquarium on your left to stop light. Go straight across intersection. Office building will be on your 1st left after the Hilton. Entrance is located in the back of the building. Thru doors with green awning.

EAST LYME DIRECTIONS- 314 Flanders Road-phone 860-739-3011

From 95 going North (From the Old Saybrook/Essex area)

Take exit 74 (Flanders/Niantic/Rte 161 Exit), Turn left at end of ramp, go under Route 95 overpass. The office is located in the Liberty bank complex, the 4th driveway after True value.

From 95 going South (from the Groton/New London/Waterford area) or Route 395 South

Take Exit 75 (Flanders/Waterford/Rte 1 Exit)
At traffic light turn left onto Route 161/ Flanders road and stay in the right hand land.
The office is located in the Liberty Bank complex, the 3rd driveway on the right.

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PATIENT QUESTIONNAIRE

Name: First:_____ **MI**_____ **Last:**_____

Date of Birth (MM/DD/YY):_____/_____/_____

Referred? Y N **Referred by**:_____

Primary Care Physician:_____ Please provide physician seen within the last year

Upon the completion of your workup, a copy of the consult will be provided to the referring provider.

List any additional physician to receive a copy of the consultation:

_____

_____

After completing the above information, please complete ALL sections below to the best of your ability.

A. Chief Complaint: Why are you seeing the doctor? (rash, cough, wheezing, congestion, runny nose, hives, allergic reaction, etc.)

_____
_____
_____
_____

B. What seems to make your symptoms worse (circle)?

dust trees grass weeds mold
feathers exercise cold air smoke stress
weather changes strong odors menstruation
respiratory infections Other:

animals (list)_____
foods (list)_____

C. When are your symptoms worse?

Jan Feb March Apr May June July
Aug Sept Oct Nov Dec Year-Round

I don't know N/A

Time of day?_____

D. Do you have a history of allergies or reactions to the following (circle):

Bee/other insect Aspirin or other NSAIDs
Latex Local Anesthetics
Pollen/Dust/Dander Other (list)

E. Past Medical History, Current Conditions or Illnesses (e.g. diabetes, thyroid, high blood pressure, pneumonia etc.):_____
_____
_____
_____
_____

G. Surgical History (type and approximate dates):

_____
_____
_____
_____
_____
_____
_____

F. Family History: Please indicate the relatives who have allergic diseases (list the types: asthma, hay fever, eczema, hives, drug, insect sting, food, etc).

Mother:_____

Father:_____

Brother(s):_____

Sister(s):_____

Children:_____

(CONTINUE ON BACK PAGE)

H: Social History:

Occupation/Grade:_____ **N/A**

Daycare? **Yes** **No** **N/A**

Pets:_____ **none**

Significant occupational/environmental exposures?_____

Do any smokers live in the household? Yes No

If patient age >13 years. Please answer:

Have you smoked? **Yes** **No** If yes, start date:_____

Still smoking? **Yes** **No** If no, quit date:_____

How many packs a day?_____

I. Medication Allergies:
(Approximate date and reaction)

_____

_____

_____

J. Medications: List all *currently* prescribed medications and over-the-counter medications you are taking:

Name Dose Frequency Date started

Patient name (print name)_____

Guardian (name/relation)_____

Patient/Guardian Signature:_____date:_____

****PLEASE DO NOT WRITE BELOW THIS LINE - FOR PHYSICIAN USE ONLY****

Sections A-J reviewed and additional notes documented by:

Physician Signature_____Date _____

Intake/visit form

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Patient _____D.O.B. ___/___/___ Sex ___M___F

Patient S.S.# _____ Interested in Practice Portal? Yes No

Address: _____City_____State_____Zip_____

Phone Number: _____/_____ Cell Number _____/ _____

Pharmacy: _____ City _____ Phone _____

Primary Care Physician (seen within the past year) _____

How did you hear about us? MD Friend/Relative Newspaper Internet Other

If MD, Referring Physician _____

Parent or Guardian's name _____S.S # _____

1st insurance: _____Group#/Name_____

Policy Holder: _____D.O.B ___/___/___ SS # _____

Id number _____ Employer _____

Policy Holders address if different from patients:

Address: _____City_____State_____Zip_____

2nd insurance: _____Group#/Name_____

Policy Holder: _____D.O.B ___/___/___ SS # _____

Id number _____Employer _____

Policy Holders address if different from patients:

Address: _____City_____State_____Zip_____

- You are responsible to know what is covered by your insurance.
    1) Is the doctor you will be seeing participating with your particular insurance plan?
    We do not accept Connecticut Medicaid insurance.
    2) What are the terms of your **allergy coverage?**
    3) Office visit co-pay?
    4) Allergy testing co-pay?
    5) Deductible?
    6) Referral needed?
- **Please have your insurance card ready for the secretary to copy**
- **Co-payments are due at time of service. A $ 5.00 statement processing fee will be added to account if co-pay is not paid at the time of the visit.**
- **Please call 24 hours in advance if you are unable to keep the appointment**
- **No show of initial appointment may result in appointment NOT being rescheduled**
- **It is the policy of this office that the parent who initiates medical care bare financial responsibility**

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I understand that I am financially responsible for all services rendered if my insurance requires a referral from my primary care physician and I have failed to procure one for my visits with Shoreline Allergy and Asthma Associates, LLP

I hereby authorize Shoreline Allergy and Asthma Associates to apply for benefits in my behalf for covered services rendered. I request payment from the insurance carrier be made directly to Shoreline Allergy and Asthma. I authorize the release of any necessary information, including medical information for this or any related claim, to the billing agent.

Signature of patient or guardian _____Date_____

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PATIENT CONFIDIENTIALITY/PROVIDING OF INFORMATION TO AND/OR FROM AUTHORIZED PARTIES

Patients often give us permission to discuss information with family or other individuals.

If you want us to be able to talk to someone, we need to verify your permission.

I, _____, hereby authorize Shoreline Allergy & Asthma Associates LLP
(**patient name**)
to give out any information regarding myself with relation to my care. I authorize the disclosure of any information regarding myself, scheduling my appointments, canceling my appointments, refilling my prescriptions, or any other information pertaining to myself with regard to Shoreline Allergy & Asthma Associates LLP with the authorized parties listed below.

1. **You may leave a message and/or discuss my personal medical information with the following people.**
   If you don't give permission for us to talk to anyone, leave blank.

   _____ Relationship:_____

   _____ Relationship:_____

   _____ Relationship:_____

   _____ Relationship:_____

2. **Some method of contact must be provided. Please indicate your choice(s) below.**

☐ You may contact me by phone at Home. _____ Work_____ Cell _____

☐ You may leave a recorded message at □ Home □ Work □ Cell number indicated above.

☐ You may leave a message regarding my appointment with _____

_____ _____

☐ You **may not** contact me by phone.

☐ You may contact by mail : home address as above or other address as follows:

_____ City: _____ State: _____ Zip:_____

3. **Please choose 1 option for appointment reminders** ☐ Voice Mail @ _____
   ☐ Text Message @ _____
   ☐ Email Message @ _____

4. **In the case of an emergency please contact:** _____
   Relationship to patient: _____ Phone number: _____

Signed _____(Patient/Parent/Guardian) Date:_____

When you check in at the office you will be given a copy of our privacy notice, financial policy and appointment /no show policy please sign and date below once you have received those documents. Thank you

_____ _____ I acknowledge that I have been given the **Financial Policy** statement.
(Initials) (Date)

_____ _____ I acknowledge that I have been given the **Privacy Notice**
(Initials) (Date)

_____ _____ I acknowledge that I have been given the **Appointment /No Show Policy**
(Initials) (Date)