



JOHN V. BOSSO, MD, FAAAAI, FAAAAI,
 LOURDES B. deASIS, MD, MPH, FAAAAI

PATIENT REGISTRATION

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security Number _____

Home Phone # _____ Cell Phone # _____

Email Address _____

Employer _____ Work Phone # _____

Referred by: _____ Primary Care Doctor: _____

How did you hear of us? _____

INSURANCE INFORMATION

Primary	Secondary
Insurance Company:	
Address:	
ID #:	
Group #:	
Policy Holder's Name	
Policy Holders Address:	
Policy Holder's Relationship to Patient:	
Policy Holder's D.O.B.	
Policy Holder's SSN:	
Policy Holder's Employer:	
Policy Holder's Work Phone:	

I hereby authorize release of any information required to process insurance claims related to services rendered by this office.

** Signature: _____ Date: _____



JOHN V. BOSSO, MD, FAAAAI, FAAAAI

LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

PATIENT INSURANCE WAIVER

I _____ have requested treatment from the Allergy & Asthma Consultants. I agree that I am responsible for all charges incurred for any visit. I understand I will be responsible for payment **if:**

- I am not insured with a participating insurance plan
- I do not provide the necessary insurance referral from my PCP on the day of my visit, if required by my plan.
- I do not provide the correct insurance information to the office
- My insurance plan has been canceled
- My insurance does not cover the services rendered
- If I don't comply with my insurance co. request for information (as an example, full time student status, other insurance information)

I am aware that some insurance companies might not cover Nasal Smears and Rhinometry tests. Therefore, I have agreed before receiving the service to pay for it myself.

Patient Signature _____ DATE _____

Authorization Of Payment

I hereby authorize payment for all medical benefits directly to Allergy & Asthma Consultants Of Rockland & Bergen P.C. (P.A.)

Patient Signature _____ Date _____

Witness Signature _____ Date _____



**ALLERGY & ASTHMA
CONSULTANTS
OF ROCKLAND & BERGEN**

JOHN V. BOSSO, MD, FAAAAI, FACAAI

LOURDES B. deASIS, MD, MPH, FACEP, FAAAAI

Patient Name

Date

If you have been referred to our practice by another physician(s), please provide us with the information below in order to help insure effective communication. We thank you in advance.

Physician's Name Address City, State & Zip Phone Number Fax Number Specialty

Physician's Name Address City, State & Zip Phone Number Fax Number Specialty



JOHN V. BOSSO, MD, FAAAAI, FAAAAI

LOURDES B. deASIS, MD, MPH, FACE, FAAAAI

ACKNOWLEDGEMENT

I, _____ (patient), acknowledge that I have received a copy of Allergy and Asthma Consultants of Rockland and Bergen's Notice Regarding Privacy of Personal Health Information.

Please give us the names of people/family members whom we may discuss/release any laboratory or test results with:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Signature

Date



JOHN V. BOSSO, MD, FAAAAI, FAAAAI,
LOURDES B. deASIS, MD, MPH, FAAAAI

Pediatric 1st Visit History Sheet (Birth-17 years)

Child's Name: _____

Child's Age: _____

Person Completing Form: _____

Date: _____

Referred by: _____

- Thank you very much for the time and effort put into filling out this form. Please complete this questionnaire before seeing the doctor. It will greatly help us learn more about your child's allergies and help us get the most out of their appointment.
- Antihistamine medications (Claritin, Clarinex, Zyrtec, Xyzal, Allegra, Benadryl, Atarax, Contac, Tylenol PM or Allergy, etc.) may interfere with skin tests for specific allergies; each antihistamine has a specific time frame for which it needs to be discontinued prior to skin testing. The office nursing staff can assist you with this.
- If your child has a holding chamber/spacer for inhaled medication, please bring it to their appointment.

Reason for Today's Visit (please describe in your own words):

1) Nose Symptoms or Eye Symptoms (when not sick)?

No (skip to next section), Yes (please fill out below)

- sneezing, nasal itchiness, throat itchiness, nasal congestion,
- decreased sense of smell, headaches, nasal pressure,
- post nasal drip, nasal discharge (color _____, thickness _____),
- mouth breathing, snoring,
- red eyes, itchy eyes, eye drainage (color _____, thickness _____), eye stinging,
- eye burning, vision changes, light sensitivity, foreign body sensation of eye,
- stringy discharge from eye

Triggers: house dust, cat, dog, temperature/humidity changes, smoke, odors, eating,
 exercise, aspirin, nonsteroidal anti-inflammatory drugs, betablockers,
 foods, menstrual cycle

How long has this been a problem? _____

Timing: year round, seasonal (winter, spring, summer, fall)

Frequency: symptoms less than 4 days per week or less than 4 weeks duration
 symptoms present for more than 4 days per week and present for more than 4 weeks
 symptoms present for 12 or more weeks

Function: symptoms do not affect sleep, work, school, sports, daily activities, playing.
symptoms affect: sleep, work or school, sports, daily activities, playing

Medications used for this problem:

Antihistamines: Benadryl(diphenhydramine), Claritin(loratadine), Clarinex(desloratadine),
 Zyrtec(cetirizine), Xyzal(levocetirizine), Allegra(fexofenedine), other _____

Nasal Sprays: Nasonex(mometosone), Rhinocort(budesonide), flonase(fluticasone),
 Nasocort(triamcinolone), Omnaris(Ciclesonide), Veramyst(fluticasone furoate),
 other nasal steroids _____, Astelin(azelastine),
 Nasal Atrovent(ipratropium bromide), Afrin, antibiotics,

Eye Drops: Patanol/Pataday(olopatadine), Zaditor(ketotifen), Alocril(nedocromil),
 Alomide(lodoxamide), Alamast(pemirolast potassium) Optivar(azelastine),
 Elestat(epinastine), Crolom/Opticrom(cromolyn), Acular(ketorolac), steroid drops,
 other

Oral steroids: no, yes Name: _____

Medications used for nasal or eye symptoms:

Which of the above medications were helpful? _____

2) Respiratory/Breathing Symptoms (Coughing/Wheezing/Shortness of Breath/Chest Tightness)? Day time/nighttime or with activity

No (skip to next section), Yes (please fill out below)

coughing/ wheezing/ shortness of breath/ chest tightness

Age of onset _____

Timing: day time, nighttime, with activity (crying, laughing, running, etc.)

Day time Frequency: never, 2 or less times/week(mi), more than 2 times/week but less than once/day(mp), daily symptoms or daily use of albuterol/xopenex(modp), continual day time symptoms or limited physical activity or frequent daily exacerbations(sp)

Night time frequency: never, 2 or less times per month,

more than 2 times a month, more than once a week, frequent nighttime symptoms

How long has this been a problem? _____

Triggers: cats, dogs, house dust, outdoors(seasonal? yes, no), colds, smoke, odors, cold, exercise, eating, stress, temp changes, aspirin, nonsteroidal anti-inflammatory drugs, betablockers, foods, , menstrual cycle

Number of missed days of school this year for these symptoms: _____

Number of times treated with oral steroids this year: _____, in lifetime: _____

Number of emergency room visits in last year for these symptoms: _____, in lifetime: _____

Number of hospitalizations in last year for these symptoms: _____, in lifetime: _____

Ever admitted to the ICU? no, yes (Intubated? no, yes)

Medications Used for this problem:

Proventil/Proair/Ventolin(albuterol), Maxair(pirbuterol),
 Xopenex(levolbuterol), Atrovent(ipratropium bromide), Flovent(fluticasone),
 Pulmicort(budesonide), Advair(fluticasone/salmeterol), Symbicort(budesonide/formoterol),
 Asmanex(mometosone), Qvar(beclomethasone), Intal(cromolyn), Tilade(nedocromil),
 Spiriva(tiotropium), Xolair(omalizumab), oral steroids, other

Medications used for respiratory/breathing symptoms:

Which of the above medications were helpful? _____

4) Eczema/Dry, itchy skin

No (skip to next section), Yes (please fill out below)

Age of onset: _____

Areas affected: face, elbows, knees, creases of arms,
 creases of legs belly chest back

Symptoms: itching, hives, redness, oozing, pale face, red face, Lightening of skin,
 Darkening of skin, darkening around the eyes, creases/folds under the eyes, chicken skin

How long has this been a problem? _____

Triggers: food, emotion, environmental contacts (_____), sweating, wool,

soaps/detergents, illness, menstrual cycle

History of Skin infections no, yes (Required: topical antibiotics, oral antibiotics, IV antibiotics)

All Medications used for this problem including creams used for skin

Name	Strength/Dose	Started	Last used	Frequency used	Any Help?
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Bathing: no, yes: (# _____ times a week, length of bath: _____ minutes)

Types of Moisturizer used: _____ :# _____ times a day

Soaps used _____ Shampoo used _____

Detergent used _____ Fabric softener: no, yes

5) Reaction to Insect Sting: Any symptoms other than local pain, redness or swelling?

No (skip to next section), Yes (please fill out below)

Skin (swelling involving large area, skin findings not at location of the sting)

Gastrointestinal (nausea, belly pain, vomiting, diarrhea, tongue swelling),

Respiratory (sneezing, runny nose, eye redness, eye itchiness, coughing, wheezing,
 hoarseness, Shortness of breath),

Cardiovascular/Neurologic (irritability, dizziness, loss of consciousness), headache

Treatment in past _____

Response to treatment _____

Date of Last sting _____

Active Epi pen/Twinject? yes, no Dose: Senior (0.3mg) Junior (0.15mg)

Expiration Date: _____

6) Hives (itchy, red, raised welts) or Giant Swelling:

No (skip to next section), Yes (please fill out below)

Possible Triggers: foods, drugs, latex, stings, heat, exercise, sweating,

cold, pressure on skin, scratching, sunlight, other triggers: _____

Number of Episodes: _____

Date of Last Episode: _____

Do individual hives last more than 24 hours? no, yes

Any bruising on skin when hives heal? no, yes

3) Reaction to Foods?

No (skip to next section), Yes (please fill out for each food separately below) If your child reacted to more than three foods, please print out or ask for an additional sheet.

<p>Suspected food: _____</p> <p>Route of Contact: <input type="checkbox"/> Ingested, <input type="checkbox"/> Inhaled, <input type="checkbox"/> Contact with eye or skin</p> <p>Symptoms: Skin (<input type="checkbox"/> Hives, <input type="checkbox"/> Eczema, <input type="checkbox"/> Itching, <input type="checkbox"/> Swelling [<input type="checkbox"/> Extremities, <input type="checkbox"/> Face, <input type="checkbox"/> Lips], <input type="checkbox"/> Flushing, <input type="checkbox"/> Sweating)</p> <p>Gastrointestinal (<input type="checkbox"/> Nausea, <input type="checkbox"/> Belly pain, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Tongue swelling),</p> <p>Respiratory (<input type="checkbox"/> Sneezing, <input type="checkbox"/> Runny nose, <input type="checkbox"/> Eye redness, <input type="checkbox"/> Eye itchiness, <input type="checkbox"/> Coughing, <input type="checkbox"/> Wheezing, <input type="checkbox"/> Hoarseness, <input type="checkbox"/> Shortness of breath),</p> <p>Cardiovascular/Neurologic (<input type="checkbox"/> Irritability, <input type="checkbox"/> Dizziness, <input type="checkbox"/> Loss of consciousness), <input type="checkbox"/> Headache</p> <p>Time between eating and reaction: <input type="checkbox"/> Immediate, <input type="checkbox"/> _____ minutes, <input type="checkbox"/> _____ hours, <input type="checkbox"/> _____ days</p> <p>Associated with activity or exercise (<input type="checkbox"/> Yes, <input type="checkbox"/> No)</p> <p>Number of times reaction has occurred: _____</p> <p>Smallest amount of food needed to cause reaction _____, Largest amount of food observed _____</p> <p>Most recent reaction _____, Last exposure _____</p> <p>Is the food being avoided? <input type="checkbox"/> Yes, <input type="checkbox"/> No: Do you read labels to avoid the implicated food? <input type="checkbox"/> Yes, <input type="checkbox"/> No</p> <p>Treatment in past _____, Response to treatment _____</p> <p>Active Epi pen/Twinject? <input type="checkbox"/> Yes, <input type="checkbox"/> No Dose: <input type="checkbox"/> Senior (0.3mg) <input type="checkbox"/> Junior (0.15mg)</p> <p>Expiration Date: _____</p>
<p>Suspected food: _____</p> <p>Route of Contact: <input type="checkbox"/> Ingested, <input type="checkbox"/> Inhaled, <input type="checkbox"/> Contact with eye or skin</p> <p>Symptoms: Skin (<input type="checkbox"/> Hives, <input type="checkbox"/> Eczema, <input type="checkbox"/> Itching, <input type="checkbox"/> Swelling [<input type="checkbox"/> Extremities, <input type="checkbox"/> Face, <input type="checkbox"/> Lips], <input type="checkbox"/> Flushing, <input type="checkbox"/> Sweating)</p> <p>Gastrointestinal (<input type="checkbox"/> Nausea, <input type="checkbox"/> Belly pain, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Tongue swelling),</p> <p>Respiratory (<input type="checkbox"/> Sneezing, <input type="checkbox"/> Runny nose, <input type="checkbox"/> Eye redness, <input type="checkbox"/> Eye itchiness, <input type="checkbox"/> Coughing, <input type="checkbox"/> Wheezing, <input type="checkbox"/> Hoarseness, <input type="checkbox"/> Shortness of breath),</p> <p>Cardiovascular/Neurologic (<input type="checkbox"/> Irritability, <input type="checkbox"/> Dizziness, <input type="checkbox"/> Loss of consciousness), <input type="checkbox"/> Headache</p> <p>Time between eating and reaction: <input type="checkbox"/> Immediate, <input type="checkbox"/> _____ minutes, <input type="checkbox"/> _____ hours, <input type="checkbox"/> _____ days</p> <p>Associated with activity or exercise (<input type="checkbox"/> Yes, <input type="checkbox"/> No)</p> <p>Number of times reaction has occurred: _____</p> <p>Smallest amount of food needed to cause reaction _____, Largest amount of food observed _____</p> <p>Most recent reaction _____, Last exposure _____</p> <p>Is the food being avoided? <input type="checkbox"/> Yes, <input type="checkbox"/> No: Do you read labels to avoid the implicated food? <input type="checkbox"/> Yes, <input type="checkbox"/> No</p> <p>Treatment in past _____, Response to treatment _____</p> <p>Active Epi pen/Twinject? <input type="checkbox"/> Yes, <input type="checkbox"/> No Dose: <input type="checkbox"/> Senior (0.3mg) <input type="checkbox"/> Junior (0.15mg)</p> <p>Expiration Date: _____</p>
<p>Suspected food: _____</p> <p>Route of Contact: <input type="checkbox"/> Ingested, <input type="checkbox"/> Inhaled, <input type="checkbox"/> Contact with eye or skin</p> <p>Symptoms: Skin (<input type="checkbox"/> Hives, <input type="checkbox"/> Eczema, <input type="checkbox"/> Itching, <input type="checkbox"/> Swelling [<input type="checkbox"/> Extremities, <input type="checkbox"/> Face, <input type="checkbox"/> Lips], <input type="checkbox"/> Flushing, <input type="checkbox"/> Sweating)</p> <p>Gastrointestinal (<input type="checkbox"/> Nausea, <input type="checkbox"/> Belly pain, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Tongue swelling),</p> <p>Respiratory (<input type="checkbox"/> Sneezing, <input type="checkbox"/> Runny nose, <input type="checkbox"/> Eye redness, <input type="checkbox"/> Eye itchiness, <input type="checkbox"/> Coughing, <input type="checkbox"/> Wheezing, <input type="checkbox"/> Hoarseness, <input type="checkbox"/> Shortness of breath),</p> <p>Cardiovascular/Neurologic (<input type="checkbox"/> Irritability, <input type="checkbox"/> Dizziness, <input type="checkbox"/> Loss of consciousness), <input type="checkbox"/> Headache</p> <p>Time between eating and reaction: <input type="checkbox"/> Immediate, <input type="checkbox"/> _____ minutes, <input type="checkbox"/> _____ hours, <input type="checkbox"/> _____ days</p> <p>Associated with activity or exercise (<input type="checkbox"/> Yes, <input type="checkbox"/> No)</p> <p>Number of times reaction has occurred: _____</p> <p>Smallest amount of food needed to cause reaction _____, Largest amount of food observed _____</p> <p>Most recent reaction _____, Last exposure _____</p> <p>Is the food being avoided? <input type="checkbox"/> Yes, <input type="checkbox"/> No: Do you read labels to avoid the implicated food? <input type="checkbox"/> Yes, <input type="checkbox"/> No</p> <p>Treatment in past _____, Response to treatment _____</p> <p>Active Epi pen/Twinject? <input type="checkbox"/> Yes, <input type="checkbox"/> No Dose: <input type="checkbox"/> Senior (0.3mg) <input type="checkbox"/> Junior (0.15mg)</p> <p>Expiration Date: _____</p>

7) Reflux/Heartburn Symptoms:

No (skip to next section), Yes (please fill out below)

- Frequent spitting up/vomiting, sour taste in mouth, bad breath, heartburn,
- back arching, coughing while/soon after eating/drinking

Medications Used: _____

8) Medication/Latex Allergies:

No (skip to next section), yes (please specify: see below)

Reaction to Medication	Description of reaction	Approximate date of last reaction
<input type="checkbox"/> penicillins		
<input type="checkbox"/> sulfa		
<input type="checkbox"/> other antibiotics		
<input type="checkbox"/> aspirin		
<input type="checkbox"/> pain relievers (Motrin/Advil/Aleve, etc)		
<input type="checkbox"/> sedatives		
<input type="checkbox"/> corticosteroids		
<input type="checkbox"/> nose sprays/drops		
<input type="checkbox"/> antihistamines		
<input type="checkbox"/> contrast/X-ray dye		
<input type="checkbox"/> latex		
<input type="checkbox"/> other		

Review of Systems:

(please indicate if your child is **currently** experiencing any of the following)

General: <input type="checkbox"/> none, <input type="checkbox"/> fever, <input type="checkbox"/> weight loss, <input type="checkbox"/> change in activity	Genital/Urinary: <input type="checkbox"/> none, <input type="checkbox"/> frequent urination, <input type="checkbox"/> pain with urination, <input type="checkbox"/> blood in urine
Endocrine: <input type="checkbox"/> none, <input type="checkbox"/> weight loss, <input type="checkbox"/> weight gain	Skin: <input type="checkbox"/> none, <input type="checkbox"/> rashes
Eyes: <input type="checkbox"/> none, <input type="checkbox"/> crossing, <input type="checkbox"/> pain, <input type="checkbox"/> redness, <input type="checkbox"/> drainage	Neuro: <input type="checkbox"/> none, <input type="checkbox"/> seizures, <input type="checkbox"/> loss of consciousness
Ear: <input type="checkbox"/> none, <input type="checkbox"/> Ear pain, <input type="checkbox"/> drainage, <input type="checkbox"/> hearing loss Nose: <input type="checkbox"/> none, <input type="checkbox"/> drainage, <input type="checkbox"/> discharge, <input type="checkbox"/> sinusitis Throat: <input type="checkbox"/> none, <input type="checkbox"/> tooth pain, <input type="checkbox"/> sore throat, <input type="checkbox"/> hoarseness	GI: <input type="checkbox"/> none, <input type="checkbox"/> feeding problems, <input type="checkbox"/> appetite changes, <input type="checkbox"/> vomiting, <input type="checkbox"/> diarrhea, <input type="checkbox"/> constipation, <input type="checkbox"/> blood in the stool, <input type="checkbox"/> abdominal pain
Respiratory: <input type="checkbox"/> none, <input type="checkbox"/> cough, <input type="checkbox"/> wheezing, <input type="checkbox"/> pauses in breathing, <input type="checkbox"/> blueness, <input type="checkbox"/> difficulty breathing	Musculoskeletal: <input type="checkbox"/> none, <input type="checkbox"/> joint swelling, <input type="checkbox"/> tenderness, <input type="checkbox"/> weakness
Cardiac: <input type="checkbox"/> none, <input type="checkbox"/> murmurs, <input type="checkbox"/> chest pain, <input type="checkbox"/> sweating with feeds	Psych: <input type="checkbox"/> none, <input type="checkbox"/> mood changes, <input type="checkbox"/> sleep problems
Hematologic/lymph nodes: <input type="checkbox"/> none, <input type="checkbox"/> bleeding, <input type="checkbox"/> anemia, <input type="checkbox"/> yellow skin or eyes, <input type="checkbox"/> swollen glands	

PLEASE FILL OUT ALL OF THE FOLLOWING

All Current Medications:

(please include over the counter, herbal remedies, eye drops, creams, nasal sprays, inhalers):

Name Dose Frequency

Past Medical History:

Other medical problems:(Please list) _____

Birth History: Full Term? yes, no (how many weeks? _____)

Method of Delivery: vaginal, caesarean (reason: _____)

Complications? no, yes (please specify: _____)

NICU stay? no, yes (length of time: _____)

Diet History: Breast fed? no, yes (length of time in months: _____)

Formula fed? no, yes (name of formula: _____)

(Age when introduced: _____)

Please list all foods that are currently avoided: _____

Infectious History:

Number of lifetime (bronchiolitis _____, croup _____)

Last (bronchiolitis _____, croup _____)

Number of lifetime (ear infections _____, pneumonias _____, sinusitis _____)

Number of infections/year (ear _____, pneumonia _____, sinusitis _____)

Last infection (ear _____, pneumonia _____, sinusitis _____)

History of none of the following: (bone infections, brain infection, skin infection,

blood infection, urinary tract infection, herpes infections, warts, trouble with live vaccines, chronic diarrhea)

Past Surgical History:(Please list all surgeries) _____

Immunizations: up to date yes, no

Any reaction? No, Yes (please specify: _____)

Date of last flu shot: _____

Social History/Environmental History:

(The questions related to the child's home also apply to other indoor environments where the child spends time, including school, daycare, car, school bus, work, and recreational facilities)

Home Characteristics: Type of dwelling: House, Apartment, Condo, Dormitory, Mobile/Motorhome

Age of dwelling: _____ years, Years of occupancy _____

Heating system: forced air(filter type _____), baseboard, hot water, radiator,
wood stove, kerosene heater

Cooling system: central air(filter type _____), room air conditioners, fans,
open windows, window fan

Filters: none, HEPA, ionizing, other _____, location of filters: _____

Mold Exposure

Mold/mildew in the home? no, yes (location: _____)

Water damage in the home? no, yes (location: _____)

Are humidifiers used? no, yes (location: _____)

Are dehumidifiers used? no, yes (location: _____)

Dust Mite Exposure

Stuffed animals? no, yes(location and number: _____)

Carpets? no, yes (wall to wall, area: locations _____)

Curtains? no, yes(location: _____)

Vacuum? no, yes (Type: HEPA filtered vacuum, standard vacuum, wet/dry vacuum)

Frequency of Vacuuming/Mopping? daily, weekly, 2x/month, monthly

Animal/Pest Exposure

Pets: Any contact with animals/pets? no, yes

Frequency of exposure: Daily, Weekly, Monthly, Rarely

Types of Animals: _____, _____, _____, _____

Location: home, relative, school, other: _____

Location in home: _____

Can they go in the child's bedroom?no, yes

Pests:cockroaches, ladybugs/ladybird beetles, mice, Location in home: _____

Child's Room

Carpets, pets, pests, stuffed animals, curtains, filters

Pillows used by child: Feather/Down, foam, rubber, synthetic, encasement (age in years _____)

Bed Mattress: conventional, vinyl, air, water: Age in years _____

When are bed linens washed/changed? daily, weekly, 2x/month, monthly, less than once a month

Smoke Exposure

Smoking in the home?no, yes

Anyone in contact with the child smokes?no, yes (amount of time exposed _____)

Does your child smoke? no, yes (age when 1st smoked _____)

Indoor/Outdoor Pollution/Chemicals

Do any people who have contact with the child have exposure to dusts, chemicals, animals, or occupational hazards?no, yes(Type of exposure: _____)

Does your child or another family member have a hobby that uses materials that are toxic or give off fumes?
no, yes(Type of exposure: _____)

How close do you live to major roadways? _____ Location (town): _____

Gas stove? no, yes(pilot light? no, yes)

New carpets, paint, floor refinishing, or other changes at your house in the past year? no, yes

Family History of Allergy:

	Eyes	Hay-fever or Sinusitis	asthma	food allergies	Eczema	Hives or Swelling	Recurrent Infections
Mother							
Father							
Siblings							
Maternal Grandparents							
Paternal Grandparents							
Other relatives							

Other Family History/Illnesses:

	Age	Illness	If deceased, cause of death
Mother			
Father			
Siblings			
Maternal Grandparents			
Paternal Grandparents			

I certify that the above information is complete and accurate.

Signature: _____ Date: _____

Relationship to patient: _____

I certify that I have reviewed the above information with the patient.

Physician Signature: _____ Date: _____



ALLERGY & ASTHMA
CONSULTANTS
OF ROCKLAND & BERGEN

JOHN V. BOSSO, MD, FAAAAI, FACAAL,
LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

**PATIENT INSTRUCTION SHEET FOR
AEROALLERGEN & FOOD ALLERGY SKIN TESTING**

You will be skin tested to important local airborne allergens and/or food allergens. These may include trees, grasses, weeds, molds, dust mites, and danders (and/or foods such as milk, egg, peanut and some others). The skin tests generally take approximately 60 minutes. Puncture tests will be performed on your back and intradermal tests on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy hive (caused by histamine release into the skin) will appear on your skin within 15 – 20 minutes. These positive reactions will gradually disappear over a period of 30 – 60 minutes, and typically, no treatment is necessary for this itchiness. Local swelling at a test site (which itches occasionally) begins 4 to 8 hours after the skin tests are applied. 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. If they are bothersome, please call the office for instructions on local treatment.

DO NOT:

1. Over the counter antihistamines should not be used 2 – 4 days prior to the scheduled skin testing. Refer to the table on the next page for specific medication and withholding time. These include cold tablets, sinus tablets, hay fever medications, or treatments for itchy skin. Some of the names of these drugs include Actifed, Drixoral, Dimetapp, Benadryl, Tavist, Trinalin, Periactin, Tylenol PM or Tylenol PM Allergy Sinus medications stating PM and many others. If you have any questions, whether or not you are using an antihistamine, please ask the nurse or doctor.
2. Medications such as over-the-counter sleeping medicines (e.g. Nytol) and other prescribed drugs such as amitriptyline hydrochloride (Elavil), hydroxyzine (Atarax/Vistaril), doxepin (Sinequan) and imipramine (tofranil) have antihistaminic activity and should be discontinued at least **two weeks prior** to skin tests.
3. If you are taking a prescription antihistamine (Allegra, Clarinex, Zyrtec, Xyzal etc.), refer to the table on the next page.
4. Patients on Astelin, Asetpro, or Patanase nasal sprays should not use these medications for 48 hours prior to the tests.



YOU MAY:

1. Continue on your intranasal allergy sprays such as Flonase, Nasalcort, Beconase, Rhinocort, Nasonex, Nasalcrom, Vancenase or Nasarel. Entex or Sudafed may also be used temporarily but not on the day of testing.
2. Most drugs do not interfere with skin testing but make certain that your physician or nurse knows about every drug you are taking.

After skin testing, you will meet with the doctor (either the same day or possibly another day) who will make further recommendations regarding your treatment.

****We request that you do not bring small children with you when you are scheduled for skin testing, unless they are accompanied by another adult who can sit with them in the waiting room. Please do not cancel your appointment since the time set aside for your skin test is exclusively yours. If for any reason you need to change your appointment, please give us at least 48 hours notice. Due to the length of time scheduled for skin testing, a last minute change results in loss of valuable time that another patient might have utilized. We thank you for your cooperation.****



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LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

EFFECTS OF ANTIHISTIMINES ON ALLERGY SKIN TESTS

Antihistimines taken orally can block responses to immediate-type allergy skin tests. Below is a list of some commonly used antihistamines and the approximate amount of time that these medications must be withheld prior to immediate hypersensitivity allergy skin tests:

<u>MEDICATIONS</u>	<u>AMOUNT OF TIME</u>
1. Benadryl/Tylenol Allergy & Sinus or PM	24 – 48 hours
2. Chlortrimeton (chlorpheniramine Short-act) 4mg	24 – 48 hours
3. Chlortrimeton 12 mg (12 hour)	3 – 4 days
4. Tavist (clemastine)	4 days
5. Claritin/Claritin D-24/Redi-tabs (loratadine)/Alavert	10 days
6. Claritin D-12 hour, Clarinex 5 mg	7 days
7. Allegra (fexofenadine) 60 mg/Allegra D-12 hour	3 days
8. Allegra (fexofenadine) 180 mg	5 days
9. Zyrtec (cetirizine)	3 – 4 days
10. Xyzal (levocetirizine)	7 days
11. Astelin, Patanase, or Astepro <u>Nasal Sprays</u>	48 hours
12. Atarax/Vistaril (hydroxyzine)	10 days
13. Periactin (cyproheptadine)	72 hours
14. Tricyclic antidepressants (Elavil, Amitriptyline, Nortriptyline)	10 – 14 days

For information on other antihistamines or medications, please feel free to contact the office at (845) 353-9600.

2 Crosfield Ave., Suite 406, West Nyack, NY 10994 – Tel: (845) 353-9600 – Fax: (845) 353-9353
354 Old Hook Rd., Suite 207, Westwood, NJ 07675 – Tel: (201) 666-8500 – Fax: (201) 666-5241
www.rballergy.com

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

For Allergy and Asthma Consultants of Rockland and Bergen (the practice)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this Notice Regarding Privacy of Personal Health Information. The Notice describes (1) how the practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the practice's duties and controls information.

I. Protected Health Information
"Protected health information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present or future physical or mental health, the provision of health care to you; and your past, present, or future payment for health care.

II. The Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Operations
Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The practice may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the practice may coordinate your health care with a third party. For example, the practice may disclose your protected health information to a pharmacy to fulfill a prescription for asthma medication, to an X-ray facility to order an X-ray, or to another physician who is administering your allergy shots, which we prepared. In addition, the practice may disclose protected health information to other physicians or health care providers for treatment activities of those other providers.

Payment. When needed, the practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the practice may also disclose you protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, the practice may also disclose you protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations. The practice may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, the practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the practice may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment, and healthcare operations, the practice may also use or disclose your protected health information to: (1) remind you of an appointment including the leaving of appointment reminder information on your telephone answering machine; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

Additional Uses and Disclosures Permitted Without Authorization or An Opportunity to Object
In addition to treatment, payment, and health care operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

- When There Are Risks to Public Health.** The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law:
- (1) Prevent, control, or report disease, injury, or disability;
 - (2) Report vital events such as birth or death;
 - (3) Conduct public health surveillance, investigations, and interventions;
 - (4) Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance;
 - (5) Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease; and
 - (6) Report to an employer information about an individual who is a member of the workforce.

To Report Abuse, Neglect Or Domestic Violence. As required or authorized by law or with the patient's agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect or domestic violence.

To Conduct Health Oversight Activities. The practice may disclose your protected health information to a health oversight agency for use in (1) audits; (2) civil, administrative, or criminal investigations, proceedings or actions (3) inspections; (4) licensure or disciplinary actions; or (5) other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the practice will not disclose protected health information that is not directly related to your receipt of health care or public benefits.

For Judicial And Administrative Proceedings. The practice may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal is expressly authorized by such order or a signed authorization is provided.

For Law Enforcement Purposes. The practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:

- (1) Required by law to report of certain types of physical injuries;
- (2) Required by court order, court-ordered warrant, subpoena, summons, or similar process;
- (3) Needed to identify or locate a suspect, fugitive, material witness, or missing person;
- (4) Needed to report a crime in an emergency situation.

You are the victim of a crime in specific limited instances; and
Your death is suspected by the practice to be the result of criminal conduct.
To Coroners, Funeral Directors, and for Organ Donation. The practice may disclose protected health information to a coroner or medical examiner for the purpose of (1) identification, (2) determination of cause of death, (3) performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the practice may disclose protected health information, including when death is reasonably anticipated, to funeral director to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadaveric organ, eye or tissue donation.

For Research Purposes. The practice may use or disclose your protected health information for research if such use or disclosure has been approved by an institutional review board or privacy board that has examined the research proposal and the research protocols which maintain the privacy of your protected health information.

To Prevent or Diminish A Serious and Imminent Threat To Health Or Safety. If in good faith the practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health and safety of the public, the practice may use or disclose your protected health information as permitted under law and consistent with ethical standards of conduct.

For Specified Government Functions. As authorized by the HIPAA privacy regulations, the practice may use or disclose your protected health information to facilitate specified government functions relating to military or veterans activities, national security and intelligence activities, protective services for the President and officers, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's Compensation. The practice may disclose your protected health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted With An Opportunity to Object

Subject to your objection, the practice may disclose your protected health information (1) to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not object to these disclosures, the practice is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgment, that it is in your best interests for the practice to disclose information that is directly relevant to the person's involvement with your care, then the practice may disclose your protected health information. If you are incapacitated or in an emergency situation, the practice may exercise its professional judgment to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly relevant to your health care.

IV. Uses and Disclosures Authorized by You

Other than the circumstances described above, the practice will not

disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

V. Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the practice holds your protected health information, you may inspect and obtain a copy of such information included in a designated record set. A "designated record set" contains medical and billing records as well as any other records that your physician and the practice uses to make decisions regarding the services provided to you. The practice may deny your request to inspect or copy your protected health information if the practice determines in its professional judgment that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:

(1) information compiled in reasonable anticipation of, or for use in, a civil;

criminal, or administrative action or proceedings and (2) protected health information that is subject to a law that prohibits access to protected health information. You may have the right to have a decision to deny access reviewed in some situations.

You must submit a written request to the practice's Privacy Officer to inspect and copy your health information. The practice may charge you a fee for the costs of copying, mailing, or other costs incurred by the practice in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record at the number given on the last pages of this Notice.

The right to request restrictions on uses and disclosures of your protected health information. You may request that the practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or health care operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the practice's Privacy Officer.

The practice may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the practice agrees to the requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The practice may terminate the agreement to a restriction in some instances.

The right to request to receive confidential communications from the practice by alternative means or at an alternative location. You have the right to request that the practice communicates with you through alternative means or at an alternative location. The practice will make every effort to comply with reasonable requests. However, the practice may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the practice's Privacy Officer.

The right to request an amendment of your protected health information. During the time that the practice holds your protected health information, you may request an amendment of your information in a designated record set. The practice may deny your request in some instances. However, should the practice deny your request for amendment, you have the right to file a statement of disagreement with the practice. In turn, the practice may develop a rebuttal to your statement. If it does so, the practice will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the practice's Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the practice's disclosures of your protected health information made for purposes other than treatment, payment or health care operations as described in this Notice. The practice is not required to account for disclosures (1) which you requested, (2) which you authorized by signing an authorization form, (3) for a facility directory, (4) to friends or family members involved in your care, and (5) certain other disclosures the practice is permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting to include up to a six-year period. The practice is not required to provide an accounting for disclosures that take place prior to April 14, 2003. The practice will not charge you for the first accounting you request of any 12-month period. Subsequent accountings may require a fee based on the practice's reasonable costs for compliance of the request.

The right to submit a paper copy of this Notice. The practice will provide a separate paper copy of this Notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

VI. The Practice's Duties

The practice is required to ensure the privacy of your health information

and to provide you with this Notice of your rights and the practice's duties and procedures regarding your privacy. The practice must abide by the terms of this Notice, as may be amended periodically. The practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that the practice collects and maintains. If the practice alters its Notice, the practice will provide a copy of the revised Notice through regular mail or in-person contact.

VII. Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. The practice encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The practice's contact person regarding the practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this Notice by request. Complaints to the practice should be directed to the Privacy Officer at the following address:

Allegry and Asthma Consultants of Rockland and Bergen

2 Crossfield Ave. Suite #406 West Nyack, NY 10994 AITN: Privacy Officer The Privacy Officer can be contacted by telephone at (845) 333-9600 or at (201) 666-8500.

X. Effective Date

This Notice is effective on April 14, 2003.