



Tina C. Zecca, DO

## ALLERGY & ASTHMA ASSOCIATES OF MONMOUTH COUNTY

200 White Road Ste #205 224 Taylors Mills Road Ste #103  
Little Silver, NJ 07739 Manalapan, NJ 07726  
(732) 741-8222 Little Silver (732) 847-9910 Manalapan  
(732) 741-6217 Little Silver fax (732) 847-9913 Manalapan fax

Welcome to Allergy & Asthma Associates of Monmouth County! Your appointment has been scheduled in our Little Silver/Manalapan office on \_\_\_\_\_@\_\_\_\_\_.

For your appointment, please bring all insurance cards to the office as well as any copay due. Your copay is due at the time of the visit and cannot be billed to you. If your insurance plan requires a referral, PLEASE MAKE SURE YOU CONTACT YOUR PRIMARY CARE PHYSICIAN and request the referral prior to your appointment. If you do not have a referral for your visit, your appointment will be rescheduled.

You have been scheduled for skin testing. It is very IMPORTANT that you review this medication list prior to your visit so that we may accurately diagnose your allergy. If there are any questions as to the medication that you are taking and whether it will interfere with skin testing, please call the office or consult with your pharmacy.

**Intranasal steroid sprays and asthma medications WILL NOT INTERFERE WITH TESTING. They are as follows:**

Flonase=Fluticasone, Nasonex=Mometasone, Nasacort=Triamcinolone, Rhinacort, Q-Nasl, X-Hance, Flovent Inhaler, Albuterol Inhalers, Breo, Advair, Symbicort, Dulera, Pulmicort, Arnuity, Asmanex, Qvar and Alvesco.

**AVOID the following medication 5 full days prior to skin testing:**

Atarax=Hydroxyzine, Polarmine=Dexachlorpheniramine, Clarinex=Desloratadine, Xyzal=Levocetirizine, Tavist=Clemastine.

**AVOID the following medications 3 full days prior to skin testing:**

Benadryl=Diphenhydramine, Phenergan cough medication=Promethazine, Bromfed, Dimetapp=Brompheniramine, Semprex-D, Zyrtec=Cetirizine, Allegra=Fexofenadine, Claritin=Loratadine, Ryvent, Ryclora.

**AVOID the following nasal antihistamine sprays at least 3 days prior to skin testing:**

Dymista, Astepro, Astelin=Azelastine, Patanase=Olopatadine

**PLEASE INFORM YOUR ALLERGIST IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS PRIOR TO YOUR TESTING APPOINTMENT-BUT DO NOT STOP TAKING THE MEDICATION:**

Xanax-Alprazolam, Doxepin, Zyprexa=Olanzapine

PLEASE INFORM THE OFFICE IF YOU HAVE ASTHMA SYMPTOMS OR FEVER WITHIN 24 HOURS OF YOUR APPOINTMENT!!

Be advised if you arrive more than 10 minutes late for your appointment, you will be asked to reschedule as a courtesy to the doctor and your fellow patients.



**PATIENT REGISTRATION FORM**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Alternate # \_\_\_\_\_

Email Address \_\_\_\_\_

DOB \_\_\_\_\_ Gender M F

Primary Care Dr.'s Name \_\_\_\_\_

Primary Care Dr.'s Phone # \_\_\_\_\_

Referring Dr.'s Name \_\_\_\_\_

Referring Dr.'s Phone # \_\_\_\_\_

Guarantor Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Email Address \_\_\_\_\_

DOB \_\_\_\_\_ Gender M F

Primary Insurance Co. \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_

ID # \_\_\_\_\_ GRP # \_\_\_\_\_

Copay \_\_\_\_\_ Policyholder Name \_\_\_\_\_

DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_

ID # \_\_\_\_\_ GRP # \_\_\_\_\_

Copay \_\_\_\_\_ Policyholder Name \_\_\_\_\_

DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_



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**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **MI** \_\_\_\_\_

Local Pharmacy Name \_\_\_\_\_

Local Pharmacy Address \_\_\_\_\_

Local Pharmacy Phone # \_\_\_\_\_

Mail Away Pharmacy Name \_\_\_\_\_

Mail Away Pharmacy Phone # \_\_\_\_\_

Chief Complaint (the reason for your visit) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medications** (please list name & dose)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_
- 9) \_\_\_\_\_
- 10) \_\_\_\_\_



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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

## Past Medical & Allergy History:

Please list ALL Medical History (i.e.: heart attack, bronchiolitis) \_\_\_\_\_

\_\_\_\_\_

Surgeries (list type & dates) \_\_\_\_\_

Food Reactions (list food & reaction) \_\_\_\_\_

Drug Reactions (list drug & reaction) \_\_\_\_\_

Have you ever had a reaction to Latex? Yes No (if yes, type of reaction) \_\_\_\_\_

Have you ever been stung by an insect? Yes No (if yes, type of reaction) \_\_\_\_\_

## Birth History (for patients 0 to 18 years)

Full Term: Yes No. Vaginal or C-Section Birth Weight: \_\_\_\_\_ lbs. \_\_ oz.

Was your child breastfed? Yes No If so, for how long? \_\_\_\_\_

Are your child's immunizations up to date? Yes No

## Environmental History:

Home: Apartment House Condo Length of Occupancy: \_\_\_\_\_

Heat: Forced Hot Air Radiator Baseboard

Air Conditioning: Central Window

Humidifier: Built-In Room Dehumidifier: Built-In Room

Basement: Concrete Carpeting Tile Is your basement: damp musty dry

Does your basement flood? Yes No

Bedroom Floor: Hardwood Carpet Tile Hardwood w/ area rugs

Pillows: Regular Down Memory Foam

Blankets: Regular Down

Pets: Dog Cat Bird Other: \_\_\_\_\_

Do your pets go in the bedroom? Yes No



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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_

Marital Status: Married    Single    Widowed    Divorced

Do you smoke?    Yes    No    If so, how much do you smoke? \_\_\_\_\_

Do you vape?    Yes    No    If so, how much do you smoke? \_\_\_\_\_

How long have you smoked? \_\_\_\_\_

If you do not smoke presently, are you a former smoker?    Yes    No

If yes, how long did you smoke? \_\_\_\_\_

If yes, how much did you smoke? \_\_\_\_\_

Do you drink alcohol?    Yes    No    If so, how much do you drink? \_\_\_\_\_

How often do you drink? \_\_\_\_\_

**Family History:**

Please list any family members with any history of allergies

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Please list any family members with any history of asthma

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**Patient Name (please print)** \_\_\_\_\_

**Patient Signature (parent, if patient is a minor )** \_\_\_\_\_

**Patient's date of birth** \_\_\_\_\_ **Today's date** \_\_\_\_\_



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## DISCLOSURE RELEASE

**I hereby give permission to release my information about my treatment given** by Allergy & Asthma Associates of Monmouth County to my insurance company.

**I hereby give permission for my insurance company to make payment directly to:** Allergy & Asthma Associates of Monmouth County.

I understand that I am responsible for my co-pay (**THAT MUST BE PAID AT THE TIME OF THE VISIT**), plus any deductible and/or co-insurance indicated on my Explanation of Benefits as my responsibility. Services such as allergy testing and/or pulmonary function testing are examples of charges that my fall into this category. Furthermore, I understand that even though Allergy & Asthma Associates of Monmouth County "PARTICIPATES/IN-NETWORK" with my insurance company I will still be responsible for said "deductible/co-insurance" amounts as dictated by my insurance company. These amounts will be billed to me once my insurance company processes my claim.

It is the responsibility of the patient, or guarantor/subscriber, to provide the office with any updates/changes to my insurance PRIOR to being seen by the Dr. A valid insurance card must be presented at check-in. Patients who arrive without proof of insurance MAY be unable to seen that day. Furthermore, I understand that if referrals are needed it is my responsibility to obtain them and ensure the office is provided said referral information. If a referral is NOT obtained, or provided to the office before being seen by the Dr, the balance for that days' services will be my responsibility.

If I arrive more than 10 minutes late, my appointment MAY be rescheduled at the discretion of the office.

If I do not show for a scheduled appointment, my account will be **billed \$50.00 no show fee.**

Appointment reminders will be sent by text or email (text & messaging rates may apply)

A form completion fee of \$10.00 will be charged **for each instance** the Dr. and/or office staff is asked to complete paperwork. This is for standard forms such as Allergy Action Plan, Asthma Treatment Plan and Medication Administration forms. More complex forms and/or narrative letters will be billed at a higher fee.

The patient will be notified of the fee when the forms are left with the office.

**All form completion fees must be paid at the time the forms are dropped off.**

**Forms sent by fax or email will not be accepted!**

All completed forms must be picked up at the office. There is no fee for assessed for office notes sent to another physician.

If a balance goes unpaid for more than 60 days my account MAY be referred to an outside collection agency and/or reported to the credit bureau agencies. All fees associated with the collection efforts will be the patient/guarantor's responsibility.

Billing statements will be sent via text, or email, each of the first several attempts to collect any outstanding balance. (text & messaging rates may apply) If no response is received a paper statement will be mailed to the primary address on file.

**Patient Name** (please print) \_\_\_\_\_

**Patient Signature**(parent, if patient is a minor ) \_\_\_\_\_

**Patient's date of birth** \_\_\_\_\_ **Today's date** \_\_\_\_\_



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### Authorization for Disclosure of Protected Health Information

Our office reserves the right to leave messages on your voicemail regarding your appointment and/or billing issues if our attempts to speak with you personally have failed. I authorize my physician and/or staff to disclose the following protected health information to:

Myself Only

My spouse, significant other, parent (specify name) \_\_\_\_\_

Other (please specify name and relationship) \_\_\_\_\_

### Please check your choice of information to be disclosed

Yes, I give permission for ANY/ALL information to be left on my voicemail.

Lab/Test Results

Diagnosis

NO, I DO NOT WANT MEDICAL INFORMATION LEFT ON MY VOICEMAIL

I further acknowledge that I have been informed of the new Notice of Privacy Practices under the HIPAA laws effective September 23, 2013.

I understand that I have the right to revoke this authorization, in writing, to the office manager at:  
ALLERGY & ASTHMA ASSOC OF MONMOUTH COUNTY, 200 WHITE ROAD. SUITE 205,  
LITTLE SILVER, NJ 07739

I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy rule or State Law.

**Patient Name (please print)** \_\_\_\_\_

**Patient Signature**(parent, if patient is a minor ) \_\_\_\_\_

**Patient's date of birth** \_\_\_\_\_ **Today's date** \_\_\_\_\_