NARBERTH ALLERGY & ASTHMA

Narberth Allergy and Asthma-Havertown

Corinna Bowser, MD| Linda D. Green, MD
109 Forrest Ave, Narberth, PA | 850 West Chester Pike, Havertown, PA
Phone: 484-270-8584 Fax: 484-270-8799 | Phone: 610-446-4844 Fax: 610-446-3901
E-Mail: narberthallergy@gmail.com Web: www.narberthallergy.com
ldgreen@sniffles.com www.sniffles.com

WELCOME TO OUR PRACTICE

TO THE NEW PATIENT:

Your appointment is scheduled for the following date and time:

Date:_____ Time:_____

Please complete the enclosed forms and bring them with you when you come in for your appointment. If you are unable to complete them before your visit, please come in 20 minutes early in order to complete them.

Our office is located at 850 West Chester Pike, Suite 300, Havertown, PA 19083. Please remember that all copayments are due at the time of your visit. We accept only cash or checks.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, WE REQUIRE A MINIMUM OF 24 HOURS NOTICE SO THAT ANOTHER PATIENT MAY BE GIVEN YOUR APPOINTMENT.

Dr. Linda Green and **Dr. Corinna Bowser** are physicians with subspecialty training in Allergy and Clinical Immunology. They are Diplomats of the American Board of Allergy and Immunology and the American Board of Pediatrics. Their practice is limited to pediatric and adult allergy, asthma, and immunology.

OFFICE HOURS AND APPOINTMENTS

Office hours are by appointment only. Appointments may be made by calling (610) 446-4844. The office is located at 850 West Chester Pike, Suite 300, Havertown, PA 19083. We are approximately 2 miles east of exit 9 of the Blue Route.

Patient Office Hours:

Monday	9:00 am – 6:00 pm (Dr. Bowser)
Wednesday	1:00 pm – 7:00 pm (Dr. Green)
Friday	9:00 am – 1:00 pm (Dr. Green)

A minimum of twenty-four (24) hours notice is required for cancellation of appointments so that another patient may be given your appointment time. We reserve the right to charge for missed appointments. Please make every effort to keep your appointment as broken appointments are an inconvenience to all, especially for those patients who are waiting for appointments.

INSURANCE AND FEES

Drs. Green and Bowser participate with most major health plans in the area. Please check with our office or your insurance company for more information.

Allergy evaluations may be partially or totally covered by your insurance. In order for us to bill your insurance , you must bring your insurance identification card and any other necessary insurance information with you at the time of your visit. Otherwise you will be responsible for the bill at the time of service

Patients who belong to an HMO or POS (Point of Service) plan requiring referrals must have a valid referral (paper or electronic) from their primary care physician (PCP) at the time of their visit or they will be rescheduled. Please note that many PCPs require several days notice to prepare referrals. If you are unable to obtain your referral prior to your appointment, please call our office and we will gladly reschedule your visit.

Many insurance plans also have copayments, deductibles and coinsurance which are the patient's responsibility. ***All copayments, deductibles and coinsurance are due at the time of the visit.*** We accept cash, checks or money orders for all payments.

Our fees are comparable to those charged by other board-certified allergists practicing in the Delaware Valley. Whenever possible we prefer that patients pay at the time of service if we do not participate with their insurance. When statements are sent out, payment is due upon receipt. If you are unable to pay your bill in full, please contact the office and we will assist you in outlining an acceptable payment schedule. We are willing to cooperate with you in any way we can, but cannot do so if you do not ask for assistance. If it is necessary to bill for copayments, a service charge of $15.00 will be added to the bill.

YOUR INITIAL VISIT

We ask patients to fill out an allergy questionnaire, which is available on our web site at **www.sniffles.com** and bring it to the appointment. ***Please bring any medical records, lab tests, skin tests or X-ray reports previously done that may be pertinent to your problem***. ***Please bring a list of all your medications or the actual medicines if a list is not available.*** The purpose of this visit is to obtain a detailed allergy history and physical examination to establish the nature of the problem and whether allergy therapy is indicated. The mechanics of an allergy evaluation will be discussed and a course of action outlined. If it is felt that you or your child would benefit from allergy testing, skin testing will be done.

SKIN TESTING

Allergy skin testing remains the quickest, most sensitive and most cost-effective way of identifying allergies. Skin testing usually requires one or two sessions to complete. The total number of skin tests may vary, but rarely exceeds sixty. While most people have a fear of allergy skin tests, they produce minimal discomfort. If your child is to be tested, we will be happy to demonstrate the skin test on you if you so desire. The tests are read approximately 15-20 minutes after application. Following completion of testing, the results of your evaluation and appropriate therapy will be discussed.

Antihistamines will interfere with skin testing resulting in negative tests. These medications must be stopped at least 4 days before skin testing is to be done.

All other medications should be continued especially those for asthma. If you are uncertain whether a medicine should be stopped before your visit please call your primary care physician or our office. Patients who cannot stop antihistamines before the visit due to severe symptoms or who inadvertently take antihistamines before the visit will be seen for a consultation to determine the appropriate treatment and what further evaluation is necessary. Medications will be changed if necessary and skin testing will be done at a subsequent visit.

Patients with hives, other skin problems, drug allergy or bee sting allergy do not need to stop antihistamines before the initial visit. If these conditions require skin testing it will be done at a subsequent appointment as special preparations are required.

ALLERGY SHOTS (IMMUNOTHERAPY)

If it is recommended that you receive allergy shots, your treatment program will be outlined upon completion of skin testing. You may receive your injections in this office or take your allergy extract to your primary care physician to administer. Certain insurance plans (HMO and POS plans) may require patients to receive allergy injections in the primary care physician's office. We require that a medical person (doctor, nurse or physician's assistant) administer allergy injections in a medical setting. Patients or parents should not give allergy shots. It is necessary to remain in the office 30 minutes after your injection and have your arms checked for any local reaction.

REMEMBER: YOU MUST DISCONTINUE ANTIHISTAMINES AT LEAST 4 DAYS PRIOR TO YOUR VISIT IN ORDER TO BE SKIN TESTED. PLEASE CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS. BE SURE TO VISIT OUR WEB SITE (www.sniffles.com) FOR MORE INFORMATION. THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR ALLERGY CARE.

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Patient information:

Name: _____Sex: M / F DOB: _____Age:____y

Address: _____

Phone (home): _____ (cell): _____ (work): _____

Email_____ Social security number: _____

Occupation: _____ Marital status: single/married/divorced/widowed

Family physician: _____ Pharmacy: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Insurance:

Subscriber's name: _____ Date of birth: _____

Address: _____ Social security # _____

City/Sate/Zip:_____ Relationship to patient: _____

I authorize the release of any medical information necessary to process all claims.

I authorize payment of medical benefits to Narberth Allergy and Asthma for services rendered. I also understand that my signature may be used as signature on file for insurance purposes. It is your responsibility to know and comply with the terms of your insurance contract. In the event your health plan determines a service to be "not covered", or payment is denied due to failure to comply (no referral, pre-existing condition, etc), you will be responsible for the complete charge.

Call your health plan if you have any questions regarding your coverage. For all services rendered to minor patients, we will look to the guardian for payment.

Signature of Patient/Guardian: _____

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Name: _____ **DOB:** _____

Home/daytime contact phone number:_____

May we leave a message with other residents? _____ Yes _____ No

May we leave a message on your home answering/voicemail? _____ Yes _____ No

To whom may we talk to about your medical treatment?

1. Name _____ Relationship _____

Home Phone No. _____ Cell No. _____

Other Phone No. _____

Is this person an emergency contact also? _____ Yes _____ No

2. Name _____ Relationship _____

Home Phone No. _____ Cell No. _____

Other Phone No. _____

Is this person an emergency contact also? _____ Yes _____ No

If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.

Patient/Parent/Legal Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that I was offered a copy of the Notice of Privacy Practices (HIPAA) and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient/Parent/Legal Guardian Signature _____Date _____

CONSENT TO OBTAIN PRIOR MEDICATION HISTORY FROM THIRD PARTY (surescripts)

I herewith consent for Narberth Allergy to obtain my medication history as available from third party (my pharmacy and surescripts).

Patient/Parent/Legal Guardian Signature _____Date _____

Linda D. Green, M.D.
Allergy Questionnaire

Name: _____ Age: ____ Gender:____ Date of Appointment:_____

Reason for Visit
What brings you to the office today?
_____
_____
_____
Date symptoms started? _____
Have you missed days from work or school?
☐ Yes ☐ No How many _____

Past Medical History
Have you ever had any of the following?

☐ Acne	☐ Headaches
☐ AIDS / HIV	☐ Heart Disease
☐ Anaphylaxis	☐ Hepatitis B
☐ Alcoholism	☐ Hepatitis C
☐ Allergies	☐ High Blood Pressure
☐ Anemia	☐ High Cholesterol
☐ Anxiety	☐ Hives
☐ Arthritis	☐ Joint Disorder
☐ Asthma	☐ Kidney Disorder
☐ Back Problems	☐ Kidney Stones
☐ Blood Disorder	☐ Liver Disease
☐ Bronchitis	☐ Lung Disease
☐ Cancer	☐ Nasal Polyps
☐ Contact Derm.	☐ Osteoporosis
☐ COPD	☐ Pneumonia
☐ Diabetes	☐ Rheumatic Fever
☐ Depression	☐ Sinusitis
☐ Ear Problems	☐ Skin Disorder
☐ Eating Disorder	☐ Sleep Apnea
☐ Eczema	☐ Stroke
☐ Epilepsy	☐ Substance Abuse
☐ Gallstones	☐ Thyroid Problem
☐ GERD/reflux	☐ Tonsillitis
☐ Glaucoma	☐ Tuberculosis
☐ Gout	☐ Sexually Transmitted Disease
☐ Hay Fever	☐ Other: _____
	_____

Hospitalizations & Surgeries (indicate date)
_____
_____
_____

Medications (List all medicines-Rx & OTC)
_____
_____
_____
_____
_____
_____
_____

Allergies & Asthma History
Are your symptoms worse in certain seasons of the year? Please check
☐ Spring ☐ Summer ☐ Fall ☐ Winter
Are your symptoms worse:
☐ At home ☐ At work ☐ On vacation
☐ Other: _____
Have you ever had allergy skin testing?
☐ Yes ☐ No When? _____
Have you ever had an allergy blood test?
☐ Yes ☐ No When? _____
Have you ever had allergy shots?
☐ Yes ☐ No When? _____
Have you had reactions to allergy shots?
☐ Yes ☐ No When? _____
Have you gone to ER for allergies/asthma?
☐ Yes ☐ No When? _____
Are you allergic to any of the following?
Medical (Provide details below):

☐ ACE Inhibitors	☐ Latex
☐ Adhesive Tape	☐ NSAIDS
☐ Anesthetics	☐ Penicillin
☐ Antibiotics	☐ Seizure Medicines
☐ Aspirin	☐ Sulfa
☐ Barbiturates	☐ Other (Please list):
☐ Codeine	
_____	
☐ Contrast Dye	_____

Food (Provide details below):

☐ Dairy	☐ Nuts	☐ Peanut
☐ Eggs	☐ Shellfish	☐ Wheat

☐ Other:
_____
_____

Environmental (Provide details below):

☐ Insect stings	☐ Grass	☐ Perfume
☐ Cats	☐ Mold	☐ Strong odors
☐ Dogs	☐ Trees	
☐ House dust	☐ Weeds	☐ Smoke

Details/Reactions:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____