Advanced Allergy Associates of New Mexico

Steven Tolber, MD Teresa Jenkins-McCord, CANP P. James Romero, CFNP

Paul Tapia, PA-C Cristina Hollowwa, PA-C Elea Ann Martinez, DNP

Dear:

On behalf of the staff and providers of Advanced Allergy Associates of New Mexico Inc. we would like to welcome you to our practice and share with you our total commitment to providing exceptional patient care and compassionate service to all our patients and their families.

Our office is open Monday through Thursday from 8am to 5pm and on Fridays from 8am to 3pm. The office is closed every day from 12pm to 1pm for the lunch hour. Patients are seen by scheduled appointments only. Our allergy injections are offered on a walk in basis for our patients that are currently on immunotherapy. Patients will be directed to the appropriate On Call Provider when calling our office after hours, including weekends and holidays.

Please do not wear perfume, cologne, after shave or scented lotions as our patients may be allergic or sensitive to these fragrances and this could trigger an asthma attack.

We request that you complete the enclosed forms and either drop off, mail back or fax your forms 2 weeks before your visit. The information will assist us with your care. Fax number is 505-237-3632.

Before your visit, please check with your insurance provider to see if your plan requires a referral from your primary care physician. If yes this must be obtained prior to your visit. We require your referral on file with our office before your scheduled appointment, if we do not have your referral two days prior to your appointment we will need to reschedule your appointment.

When you arrive for your first appointment, please bring the following with you:

1. All of your health insurance cards (we will ask for them EVERY visit)
2. Photo identification
3. PCP Address and Phone Number
4. Medical Records pertaining to any previous Allergy or Asthma care
5. Any applicable co-pays

You will receive a call to remind you of your appointment time. You must arrive 30 minutes prior to your appointment time, please allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late. We strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

If you have any questions or special needs, please notify us prior to your visit. **We do require 24 hours notice if you are unable to keep a scheduled appointment.** It is our policy that after two (2) missed appointments we reserve the right to discharge you from our practice.

Thank you for choosing Advanced Allergy Associates of New Mexico Inc. for your healthcare needs.

Sincerely

The Providers and Staff of Advanced Allergy Associates Inc.

5310 Homestead NE Ste 201, Albuquerque, NM 87110
Phone: (505) 237-2574

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PLEASE PRINT LEGIBLY ON ALL PAGES

Advanced Allergy Associates of NM			
Patient Name: (First Name Middle Initial Last Name)		**Sex:**	**Date of Birth:**
Mailing Address: (Street City, State Zip)		**Home Phone:**	**Social Security #:**
Name of Employer:		**Work Phone:**	**Occupation:**
Primary Care Physician:		**Referring Doctor:**	
Race	☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White		
Ethnicity	☐ Hispanic/Latino ☐ Non-Hispanic/Latino		
Language	☐ English ☐ Spanish ☐ _____		

Responsible Party			
Name of Responsible Party:	**Date of Birth:**	**Social Security #:**	**Phone:**
Responsible Party Address:	**Responsible Party Employer:**		**Work Phone:**
Occupation:	**Relationship to patient:**		**Sex:**

Emergency Contact		
Emergency Contact:	**Relationship to patient:**	**Phone:**

Primary Insurance Coverage			
Primary Insurance Company:	**Address:**		
Subscriber Name:	**Subscriber DOB:**	**Policy #:**	**Group #:**
Is this insurance through your employer? Yes ☐ No ☐	**Patient's relationship to insured:** Self ☐ Spouse ☐ Child ☐ Other ☐		

Secondary Insurance Coverage			
Secondary Insurance Company:	**Address:**		
Subscriber Name:	**Subscriber DOB:**	**Policy #:**	**Group #:**
Is this insurance through your employer? Yes ☐ No ☐	**Patient's relationship to insured:** Self ☐ Spouse ☐ Child ☐ Other ☐		

Authorization

Authorization To Pay Benefits To Physician: I certify that I (or my dependent) have the above insurance coverage and assign directly to Advanced Allergy Associates of NM all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that if a referral is required by my insurance company it is my responsibility to obtain one from my primary care physician.

_____ _____

Patient/Responsible Party Signature Date

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BILLING POLICY

Please bring your insurance card and present it for every appointment. At the time of visit, we require payment of any co-payment/co-insurance determined by the patient's insurance plan. Patients without health insurance are required to pay the total charge at the time of service.

It is the responsibility of the patient or guardian to verify that a Referral is valid at the time of service.
Some insurances require members to obtain a referral from their Primary Care Provider prior to their visit. If the patient does not have a valid referral, they can choose to still be seen without a referral or reschedule the appointment. If you choose to be seen without a referral, you will be asked to sign a waiver and will be responsible for payment at the time of service.

If we are not contracted with your insurance plan, we will not be responsible for collecting from your insurance company nor negotiating a settlement of a disputed claim. We cannot wait for disputed or pending claims to pay. You are responsible for payment within 45 days of service.

Our policy requires that a patients account is paid within 30 days from the first receipt of a statement. It is the responsibility of the patient or guardian to ensure payment is made. There will be a $25.00 service charge for all returned checks. Accounts turned over to a collections agency will be charged a 25% service charge.

It is your responsibility to request a cost estimate for skin testing prior to your skin testing appointment. Please familiarize yourself with the benefits of your insurance plan.

Patients who are on immunotherapy or Xolair injection schedules are required to pay their account in full monthly. All other services are required to be paid at the time of service.

You may not take your allergy extract from this office until the patient portion is paid in full.

We call to verify appointments 48 hours prior to your visit to confirm you are coming. Please call us back at least 24 hours before your appointment to confirm if we could not reach you and have left you a message. If we do not hear back from you within 24 hours prior to your appointment time, your appointment may be cancelled and you will be asked to reschedule.

Patients who carry health insurance should remember that professional services are rendered and charged to both you and your insurance company. Please be familiar with your specific insurance plan, what it covers and if you are required to have a referral prior to your visit. You should also be familiar with the participating providers for your insurance plan including laboratories and x-ray facilities as you are ultimately responsible for the entire bill.

I have read and understand the terms of the billing policy as outlined above.

Print Patient Name:_____Patient DOB:_____

Patient/Guardian Signature: _____ Date_____

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NEW PATIENT QUESTIONNAIRE

Patient Name_____Birth Date_____ Date _____

What is the reason for your visit? _____

Referring Provider _____ Primary Provider _____

Pharmacy Name, Address, and Phone _____

PAST MEDICAL HISTORY: (Do you presently have or have ever had the following conditions?)

	Yes	No		Yes	No
Allergies/Hay Fever			Hepatitis/Liver Disease		
Asthma			Gastroesophageal Reflux Disease		
Nasal Polyps			Intestinal Disorder/Celiac Disease		
Sinus Disease			Kidney Disease/Decreased Function		
Hives/Swelling			Neurological disorder/Seizure		
Eczema/Atopic Dermatitis			Migraine Headache		
Frequent Bronchitis			Stroke/Mini Stroke		
Frequent Strep Throat			Anxiety/Depression		
Frequent Ear Infections			Psychiatric disorder		
Pneumonia			Osteoporosis		
Lung Disease/COPD/Bronchiectasis			Diabetes Mellitus		
Food Allergies			Blood Disease/Cancer		
Medication Allergies			Thyroid Disease		
Insect Allergies			Heart Attack/Coronary artery disease		
Immune deficiency disorder			Heart Valve Disorder		
Sleep Apnea			Heart Failure/Cardiomyopathy		
Cataract/Glaucoma			Hypertension		
Blood clots/PE/DVT			Heart Rhythm problems/A fib		

PAST SURGICAL HISTORY:

Type of Surgery	Location (Right, Left, Bilateral)	Year

Have you had any recent chest or sinus x-rays or CT Scans? Yes No If yes, When? Where?

Have you had any recent lab work? Yes No If yes, When? Where?

FAMILY HISTORY:

Please indicate if Mother (M), Father (F), Sister (S) or Brother (B) have any of these diseases/disorders

Asthma	Cystic Fibrosis	COPD	Sinus Disease/ Polyps	Hay Fever/ Allergies	Atopic Dermatitis/ Eczema	Immune Deficiency /Autoimmune

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SOCIAL HISTORY:

Occupation: _____ Allergy symptoms at work/school? _____
Hobbies? _____ History of Cannabis use? **Yes No** If yes: Vape Smoke Edibles
Current/previous tobacco use? **Yes No Past Type:** Cigarettes Cigars Pipes Snuff Chew Dip Vape
How many packs per day? ¼ ½ **1 2 3** For how many years? _____ What year did you stop? _____
Do you use alcohol? **Yes No Former** If former, what year did you quit? _____
Type: Beer, Wine, Hard Liquor **Frequency**? Daily Weekly Monthly Occasionally Rarely Socially
Amount when you have a drink? (1 drink, 2 drinks, 3 drinks..?) _____ Last drink? _____

ENVIRONMENTAL HISTORY:

How long have you lived in New Mexico? Lifelong Resident _____ Year moved to New Mexico _____
Type of Housing? **Apartment/Condo House Townhome Mobile Home** Age of Residence/Building? _____Year(s)
Length at your current residence? _____Year(s) Setting: **Urban Rural** Are you near open fields? **Yes No**
Heating System: **Gas Electric; Furnace Boiler Central Heat Pump Wood/Pellet Stove Fireplace Space heater Ductless Mini Splits**
Cooling system **Central Heat Pump Ductless Mini Splits Evaporative cooler Ceiling Fans Window Unit**
Smokers in the home? **Yes No** If yes, who? Self ___ Spouse ___ Father ____ Mother ___ Other___
Bedding you sleep on? Box Spring _____ Foam _____ Crib_____ Allergy coverings used? Mattress_____ Pillow_____
Down bedding? Pillow____ Comforter ____ Feather Bed ____ Blanket ____
Bedroom Environment: Circle all that apply: **Blinds Drapes Stuffed Animals House Plants Books Humidifier Mold**
Flooring in the residence: Carpet ___ Hardwood/Laminate ___ Tile ___ Large area rugs ___
Vacuum: Regular HEPA Central Any damp, moldy areas of the house? **Yes No** If so, where?_____
Infestation with: Mice Rats Cockroaches Other_____
Animals in the home? **Yes No** Type and How Many: Cats____ Dogs____ Other _____
Animal exposure outside the home? Horses Cattle Chickens Other _____

MEDICATION LIST

Please list below **ALL medications that you take for any condition; include herbs and vitamins. **

Name of Medication	Strength or Dose	How Many per Day/Week	Reason for Medication

ALLERGIES: Medication/Food

NO KNOWN DRUG/FOOD ALLERGIES_____

Name of Medication, Drug, Dye, or Food	Type of Reaction/Intolerance	Severity (Mild, Mild/Moderate, Moderate/Severe, Severe)

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REVIEW OF SYSTEMS

Please indicate if you have had any of the following in the last 30 days?

	Yes	No		Yes	No
Fever	___	___	Wheezing	___	___
Chills	___	___	Change in Exercise Tolerance	___	___
Night Sweats	___	___	Snoring	___	___
Appetite Loss	___	___	Nose Bleeds	___	___
Weight Loss/Gain	___	___	Difficulty Swallowing	___	___
Fatigue	___	___	Nausea	___	___
Rash	___	___	Vomiting	___	___
Itching	___	___	Diarrhea	___	___
Swelling/Angioedema	___	___	Constipation	___	___
Itchy/Watery Eyes	___	___	Heartburn	___	___
Burning/Dry Eyes	___	___	Bloating	___	___
Facial Pressure/Pain	___	___	Belching	___	___
Nasal Congestion	___	___	Muscle Weakness	___	___
Post-Nasal Drainage	___	___	Joint Pain	___	___
Runny Nose	___	___	Headaches	___	___
Sneezing	___	___	Decreased sense of smell	___	___
Cough	___	___	Swollen Glands	___	___
Shortness of Breath	___	___	Dry mouth	___	___

General:

Have you had a COVID vaccine/series? Yes No If yes: date_____ type_____

Have you had the pneumonia vaccine shot (Pneumovax or Prevnar)? Yes No If yes, date_____

Do you take the flu shot yearly? Yes No

How many times in the last year have you had to take oral or injected steroids? _____

Are there any family situations that make you or your child's care more difficult? _____

1. **ALLERGY:** (Please circle answers.)

   Have you ever been tested for allergies? **Yes No Don't Know** What type of testing? **Skin Blood (RAST)**

   Did you get allergy shots? **Yes No** For how long? When? Helpful? **Yes No**

2. **SINUS:**

   How many times have you been treated for a sinus infection with antibiotics in the last year? _____

   Ever had sinus or nasal surgery? Yes No If yes, when? _____ Did the surgery help? **Yes No**

3. **ASTHMA:**

   In the past year, have you been to the emergency room or admitted to the hospital due to asthma? Yes No

   How many times? _____

   Most recent prednisone course?_____

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the ***Notice of Privacy Practices***.

Patient Name:_____DOB: _____Account Number: _____

Parent/Legal Guardian: _____ (PRINT)

Signature: _____ Date: _____

Please initial and complete blanks for elected permission:

_____ I give permission for Advanced Allergy Associates of New Mexico to leave detailed messages on my ____home and/or ____ cell phone. (check one or both)

_____ I give permission for Advanced Allergy Associates of New Mexico to contact me via email at:

_____.

_____ I give permission for Advanced Allergy Associates of New Mexico to text message me at cell phone number: _____.

_____ I give permission for Advanced Allergy Associates of New Mexico to speak to:

_____, my _____ regarding:
(Name) (Relationship)

_____My Medical Treatment and/or _____My Financial Information (check one or both)

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Diagnostic Test Patient Information

1. **Pulmonary Function Tests:** This test is used to measure your breathing. To perform this test you will be asked to blow into a tube. The test can be performed with or without bronchodilation.

2. **SKIN TESTING FOR ALLERGIES:** This test is used to determine what you are allergic to {pollen, pets, etc.} and will measure how severe your allergies are. The procedure consists of using a skin prick device or a small needle to inject a liquid allergy substance known as antigen below the skins surface to see if there is a reaction which would result in a positive test. When a test is positive it would have the appearance of a mosquito bite and indicate you are allergic to the substance.

While severe reactions are uncommon, skin testing carries some risk of reaction which might consist of itching, hives, nasal stuffiness, sneezing, wheezing and shortness of breath, or rarely shock; such reactions require immediate treatment with injected epinephrine and in rare severe cases, hospitalization for treatment with oxygen, fluids and drugs as needed.

CONSENT TO DIAGNOSTIC TESTING

I_____***[Patient or Parent/Guardian]*** authorize the performance of diagnostic testing as circled above. I have read and I understand the information contained on this page, which explains the nature and purpose of these diagnostic tests, the risks involved, and the possibility of complications. I understand that no guarantees or assurances are given by anyone as to the results of these tests.
I also understand that if an uncommon reaction should occur (as explained above), such reaction may require immediate treatment with the injection of epinephrine or other emergency measures if necessary.

_____ _____
Print the Name of Patient Here Date of Birth

_____ _____
Patient Signature or Parent if Minor Patient Date

_____
Witness

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I _____have read and understood the instructions on this form and have received a copy on_____for my review prior to my skin testing appointment. I understand that if I do not follow the instructions on this form my skin testing cannot be performed.

Patient/Guardian Signature_____PT DOB: _____

PREPARATION FOR ALLERGY SKIN TEST

Allergy skin testing takes up to two hours to complete. **Due to the length of this appointment, we ask that you make sure you eat prior to your arrival.** Testing consists of skin prick tests on your back and possibly additional testing with needles on your arms. After your test, the results will be reviewed by your provider and treatment options will be shared with you.

If you are scheduled for allergy skin testing, please continue using steroid nasal sprays: (Flonase/fluticasone, Nasonex/mometasone or, Nasacort/triamcinolone).
Continue Montelukast (Singulair), if prescribed.
Asthma medications (except theophylline) and skin creams for eczema do not affect skin testing. **Do not stop your asthma medications or skin creams!**

Stop medications below that contain antihistamines. They will interfere with the allergy test.

Antihistamine medications to STOP 7 DAYS Prior to Allergy Testing

Generic	*Brand name*	Generic	*Brand name*
Cetirizine	Zyrtec	**Levocetirizine**	Xyzal
Desloratadine	Clarinex	**Loratadine**	Claritin
Fexofenadine	Allegra		

Antihistamine medications to STOP 3 DAYS Prior to Allergy Testing

There are multiple store brands with the following antihistamines

Generic	*Brand name*	Generic	*Brand name*
Brompheniramine	Dimetapp	**Doxylamine**	Nyquil or Unisom
Chlorpheniramine	ChlorTrimeton	**Hydroxyzine**	Vistaril or Atarax
Clemastine	**---**	**Meclizine**	Antivert
Cyproheptadine	---	**Pyrilamine**	Midol Complete
Dimenhydrinate	Dramamine	**Tripolidine**	Actifed/Mucinex
Diphenhydramine	Benadryl/ZzzQuil		

Pain relievers: ibuprofen (Advil) or acetaminophen (Tylenol) with **PM** on the label contain an antihistamine usually Benadryl/diphenhydramine.
Sleep medications: Sominex, Unisom, Nytol contain diphenhydramine or doxylamine.
Dizziness medications: Meclizine/Antivert or Dramamine/Dimenhydrinate (as above)
Cold/Flu medications: most contain antihistamines

Note: This list includes the most common antihistamines. However, there may be some not listed that are commonly used for sleep, dizziness, or cold/flu symptoms.

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Do NOT stop other cough, cold medications below

Benzonatate	Guaifenesin	Pseudoephedrine
Delsym	Mucinex	Sudafed
Dextromethorphan	Phenylephrine	Tessalon

Antihistamine sprays/drops to STOP 3 DAYS prior to Allergy Testing

Antihistamine Nasal Sprays and Eye Drops

Generic	*Brand name - nasal spray*	*Brand name – eye drops*
Azelastine	Astelin/Astepro/Dymista	Optivar
Ketotifen	---------	Alaway/Zatidor
Levocabastine	----------	Livostin
Olopatidine	Patanase	Patanol/Pataday/Pazeo/Ryaltris

Note: Some older medications that are commonly used to treat reflux (GERD) may interfere with testing and can usually be safely stopped. These reflux medications below may affect the skin test results and should be discontinued **3 days** prior to your allergy skin test.

Medications for Reflux and Indigestion

Generic	*Brand name*
Cimetidine	Tagamet
Famotidine	Pepcid/Zantac 360 Maximum
Nizatidine	Axid

Over-the-counter Vitamins/Supplements to STOP 3 DAYS prior to testing

Vitamins to stop 3 days prior to testing: Vitamin B, Vitamin C and Multivitamins

Supplements to stop 3 days prior to testing:

Astragalus	Milk Thistle
Feverfew	Saw Palmetto
Green tea	St. John's Wort
Licorice	

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Medications That Should Not Be Stopped!

Beta-Blocker Medications

Acebutolol	Dutoprol	Nebivolol
Atenolol	Esmolol	Penbutolol
Betaxolol	Hemangeol	Pindolol
Betapace	InnoPran	Propranolol
Betimol	Istalol	Sorine
Bisoprolol	Kapspargo	Sotalol
Blocadren	Kerlone	Timolol
Brevibloc	Labetalol	Tenormin
Bystolic	Lopressor	Toprol
Carvedilol	Metoprolol	Trandate
Coreg	Nadolol	Visken
Corgard	Normodyne	Ziac

Beta-Blocker Medications may be used to treat high blood pressure, heart failure and migraine headaches. These medications may not interfere with testing, but their use may signal that allergy shots may not be a treatment option. If you take any of these medications, it is important to let us know.

Do NOT stop steroid nasal sprays

Generic	*Brand name*
Budesonide	Rhinocort
Flunisolide	Nasarel/Nasalide
Fluticasone	Flonase/Sensimist
Mometasone	Nasonex
Triamcinolone	Nasacort

Do NOT Stop any Asthma or Skin medications

Montelukast (Singulair), all asthma inhalers and ORAL steroids such as Prednisone should be continued unless instructed otherwise by your provider. Use of prednisone or similar oral steroid at higher doses than 20 mg for longer than 2 weeks may suppress skin testing. Topical steroids for skin disease should be continued. Refrain from sun exposure to the back and arms for at least a week since sun exposure suppresses skin test results and makes the skin test interpretation difficult.