Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

MICHAEL G. SHEEHAN, M.D.
Allergy /Immunology

HARCHARAN SINGH, M.D.
Allergy /Immunology

Certified by the American Board of Allergy and Immunology

Welcome to our practice!

*It is our pleasure to serve you! AARA is a subspecialty practice dedicated to the treatment of allergic and immune related diseases in the CNY area. Our physicians are **certified** with The American Board of Allergy and Immunology. You can find more about us on our website, **www.aaracny.com***

Name of Patient: _____Date of Birth:_____

Appointment with Dr._____Appt. Date &Time:_____

NEW PATIENT APPOINTMENT CHECKLIST

1. PLEASE bring your insurance card. If a referral is required, make sure it is in place *prior* to your appointment. Bring Cash, Check, or Credit Card for co-payments, co-insurance, deductibles.
2. **PAYMENT IS EXPECTED AT DATE OF APPOINTMENT.** Estimated amount $_____, call if you are printing these forms. Additional charges: breathing tests or Allergy testing if done.
3. ARRIVE 15 MINUTES EARLY to allow time to complete any paperwork not mailed to you.
4. If you want us to review any labs done at another physician's office, bring copies of lab reports.
5. We CANNOT promise testing will be done on the first visit.
6. Please do not bring children to your appointment, unless the child is the patient.
7. Bring a list of ALL medications and include name, strength and dosage of all medications.

Please bring this checklist with you to the appointment.

GENERAL INFORMATION

- Daytime phone: (315) 478-2339 Fax: (315) 478-0439
- HOURS 8AM - 5PM: Monday, Tuesday, Thursday, Friday.
- CLOSED FOR LUNCH: 12:00-12:30
- Closed Wednesday, with some holiday exceptions.
- INJECTION CLINIC: Open Monday, Tuesday, Thursday from 8:00-4:15PM.
- You must be signed in by 4:15PM or you will be asked to return.
- AARA physicians are always on call after hours. Dr. Sheehan and Dr. Singh may be reached on beeper. Emergencies only please.
- Call (315) 478-2339 for beeper #.
- A minor less than 18 years old must be accompanied by a Parent/Guardian.
- **if a parent can not be present**, the parent needs to comply with office policy and complete "Designation to permit another person to consent for Health Care". We can provide you the form upon request.
- We strongly advise that you keep your follow-up appointments. **Patients who do not cooperate with us or our policies should not expect optimal results.** **Initial please** _____

- We ask that you notify us of any prescriptions refills you need at the time of your visit.
- Patients who do not keep appointments, will be asked to schedule one before a prescription is refilled.
- A patient not seen within 6 months may be asked to schedule an appointment before any forms including school forms are processed.

AARA's FINANCIAL POLICY

- **If you have no insurance or we cannot verify insurance, full payment is due at the time of the visit.**
- **Patients with balances may be asked to reschedule non-urgent visits until payment has been made.**

ALLERGY, ASTHMA, RHEUMATOLOGY ASSOCIATES ask for the courtesy of 24 hours notice to cancel a scheduled appointment. We reserve the right to charge $30 fee for "NO SHOW"patients who fail to give 24 hour notice. This charge is not covered by insurance.

- We participate in the following plans: AARP Medicare Complete UHC, AETNA, EXCELLUS BC/BS, CDPHP, CHAMPVA, CIGNA, FIDELIS, HUMANA, INDEPENDENT HEALTH (PPO), INDIAN HEALTH SERVICES, MARTIN'S POINT, MULTIPLAN, MVP, NATIONAL GOV'T SERVICES, UMR, UNIVERA, VA, WELLCARE, UNITED HEALTH CARE, as well as, several smaller plans.
  If you do not see your insurance carrier listed, please contact them to inquire about our participation. This listing may change without notice. Please note that our relationship is with you and not with the Insurance Company.
- We do not participate in Medicaid FFS (Fee for Service). If you have Medicaid FFS as a secondary insurance and your primary insurance does not fully cover the fees, you will be held responsible for the balance.
- **It is always the patient's responsibility to make sure that necessary referrals are in place and insurance information is correct and up to date.** If it is not, or we cannot verify such information, we reserve the right to reschedule the appointment or you may be held responsible for payment.
- **All co-pays and/or deductibles are due at the time of service. If you have not met your deductible, payment in full is due at time of service.**
- If you are experiencing financial hardship, please contact us. We will be happy to discuss a payment plan with you.
- Please allow 3 business days to process prescriptions. Please allow 10 business days to copy records.

Allergy, Asthma, Rheumatology Associates reserves the right to discontinue

our professional relationship with you, if our policies are not followed.

I have reviewed and understand Allergy, Asthma, Rheumatology Associates' Office Policies of the Office. I will follow the Office Policies to the best of my ability. This notice is also available on our website.

Print Patient Name:_____ Date_____

Signature of patient (or parent, if patient is a minor)

_____ Relation_____

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

PATIENT INFORMATION FORM

NAME(FIRST)_____(MI)_____(LAST)_____

DOB ____/____/_____AGE_____ GENDER: M / F / GENDER IDENTITY:_____

MARITAL STATUS: S /M /W /D SPOUSE'S NAME_____

ADDRESS: _____

CITY_____STATE_____ZIP_____

PHONE:HOME_____WORK_____CELL_____

EMAIL:_____ SS#:_____

PRIMARY PHYSICIAN_____

ADDRESS:_____

REFERRING PHYSICIAN_____

ADDRESS:_____

RESPONSIBLE PARTY:CHECK IF SAME AS ABOVE_____

NAME(FIRST)_____(M)_____(LAST) _____

RELATION TO PATIENT_____ SS#:_____

ADDRESS: STREET _____

CITY_____STATE_____ZIP_____

PHONE HOME_____WORK_____CELL_____

DATE OF BIRTH:_____

EMPLOYER_____

INSURANCE INFORMATION:

	PRIMARY	SECONDARY
COMPANY	_____	_____
ADDRESS	_____	_____
ID#	_____	_____
GROUP#	_____	_____

Allergy, Asthma, Rheumatology
ASSOCIATES, PC

5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

MICHAEL G. SHEEHAN, M.D.
Allergy /Immunology

HARCHARAN SINGH, M.D.
Allergy /Immunology

Certified by the American Board of Allergy and Immunology

PATIENT CONSENT FORM

Please list the family members or other persons with whom we may inform about your general medical condition and discuss your medical condition in an emergency situation, including diagnosis, treatment and other health care information including payment. (It is not necessary to list your primary care physician.)

PrintName:_____PrintName: _____

Phone:_____Phone_____

Relation:_____Relation_____

I, _____, hereby authorize Allergy, Asthma, Rheumatology Associates (AARA) to release all information necessary to complete insurance forms and to secure payment. I also authorize payment for all surgical/medical services to be sent directly to AARA. I accept responsibility for all medical charges not covered by insurance. Initial_____

I agree to pay any co-pays and/or balances at the time of services unless other arrangements have been made in advance. Initial_____

Correspondence regarding medical charges will be sent to the address of the insurance holder unless other arrangements have been approved in advance. I assume responsibility for all reasonable collection costs, including attorney's fees.

I authorize AARA to send correspondence to the address I have placed on record and to leave messages on my telephone answering machine/voice mail pertaining to appointment, payment issues, test results or other personal care information unless I have provided alternative contact information in advance.

I understand and acknowledge that members of AARA, as well as its employees will have access to my/the patient's medical information as reasonable necessary to carry out continuity of care, treatment plans and recommendations, payment activities and health care operations (including, but not limited to, quality assurance activities and audits). I consent to the release of any medical information about me (and any other individuals for whom I can give consent) to my health plan and any health care providers involved in caring for me, or to such individuals as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations.

Patient
(or parent)_____Date_____
(Sign)

Relationship:_____

Nov. 11, 2019

The word "patient is specifically used in the statute, and therefore it is questionable whether a non-parent legal guardian has the power to delegate authority to a designee under the law. General obligation Law 5-1551 Parents may appoint a designee for minor children, as well as, incapacitated children. If a court has ordered that both parents must agree on health care decisions, both parents must sign this designation.

Parents Designation to Permit Another Person to Consent for Health Care

1. I/We hereby state that we are parents(s) of the child(ren) named below and there are **NO COURT ORDERS now in effect that would prohibit the exercise of the power which I/WE now seek to authorize.**
2. This designation shall permit _____, (designee) to give consent for health care services for the following individuals:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

3. This designation shall be valid from _____until and including_____.

4. As to the above named child(ren), the designee is authorized to:

_____ Consent to Immunizations

_____ Consent to general health care, including examinations and treatment

_____ Consent to dental care

_____ Consent to developmental screening

_____ Consent to mental health examination and/or treatment

The designee's authority is limited as follows:

_____

_____

5. **Revocation: I understand** that this designation shall be revoked by any of the following:

a. A parent may revoke a designation by notifying the healthcare provider either verbally or in writing, or by any other act evidencing a specific intent to revoke the designation, or by executing a subsequent designation.

b. If both parents have signed this designation, and either of the parents revokes it, the authority of the designee is revoked.

c. A designee must notify all appropriate health care providers of any revocation of his or her authority.

d. If the parent who signed a designation becomes incapacitated or dies, the designation is revoked.

_____ _____

Parent's signature Date

_____ _____

Parent's name (Please Print) Telephone Number

_____

Patient's Address

On this_____day of _____, 20____, before me the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in

his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

_____ _____
Parent's signature Date

_____ _____
Parent's name (Please Print) Telephone Number

_____
Patient's Address

On this_____day of _____, 20____, before me the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

_____ _____
Designee's signature Date

_____ _____
Designee's name (Please Print) Telephone Number

_____
Designee's Address

On this_____day of _____, 20____, before me the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

New Patient Questionnaire

Name:
For children: how is the accompanying adult(s) related to child?

Date of birth: Age: Gender:

Referring Doctor's name: _____check if self-referred

Reason for visit: (please list main symptom and how long patient had this symptom)

ROS: **Please answer all questions. Circle y/n**

Constitutional:

* Fever	y	n	* wheezing	y	n
* Weight loss	y	n	* shortness of breath	y	n
			* chest tightness	y	n

Eyes:

* itchy eyes	y	n	* heartburn	y	n
* redness of eyes	y	n	* regurgitation	y	n
* watering of eyes	y	n	* acid taste in mouth	y	n
* allergic shiners	y	n	* vomiting	y	n

ENT:

* sneezing	y	n	* eczema	y	n
* itchy nose	y	n	* hives	y	n
* stuffy nose	y	n	* angioedema	y	n
* smell/taste	normal	reduced			
* plugged ears	y	n	Neuro:		
* itchy ears	y	n	* headache	y	n
* throat clearing	y	n	* seizures	y	n
* post-nasal drip	y	n			
* sore throat	y	n	Hem/Onc:		
* snoring	y	n	* pallor	y	n
* sinus pain/pressure	y	n	* enlarged glands	y	n
* hoarseness	y	n			
			All/Imm:		
Cardio:			* food allergies	y	n
* palpitation	y	n	* bee sting allergy	y	n
* chest pain	y	n			
			Musculoskeletal:		
Resp:			* arthritis	y	n
* cough	y	n	* Raynaud's	y	n

PFSH:

Current medications: *Please list names of medication, dose and how long taken.*

Previous treatment: *Please list previous treatments*

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

Medication allergies: is the patient allergic to any medication? If so, please list the name of the medication and nature of the reaction (i.e. rash, diarrhea, etc.)

Past medical history:
Please list any previous illnesses/injuries/surgeries:

Previous allergy testing/allergy shots?

For children under 5 years of age:
Birth weight: _____ Full term/preterm _____ weeks
Breathing problems after delivery?
Breast fed/formula fed? Name of formula _____
Any problems with growth (weight or height)?
Immunizations-up to date? Yes no

Family history or allergies: (check)

Asthma	insect sting allergies	exercise asthma
Hay fever	medication allergies	nasal polyps
Sinus allergies	hives/angioedema	GI reflux
Eczema	immunodeficiency	collagen disease
Food allergies	anaphylaxis	cystic fibrosis

Social history:
Occupation (for children-name of school and grade):

Missed school/work? How much?

Does patient smoke now or in the past? Yes no How many years? _____

How many packs/day? _____ Is patient exposed to smoke? If yes, where?

Hobbies:

Environment:
Patient exposed to pets? If yes, explain.

How old is your house? Urban/suburban/rural

Stuffed toys: few lots Rooms: carpeted hardwood

Indoor plants: few several Basement: damp dry

Please note: additional questions will depend on the reason for your visit. Appropriate forms will be provided if necessary.

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

Respiratory Allergy Questionnaire

Nasal/sinus/ear/throat symptoms:
Severity of nasal/sinus symptoms: mild / moderate / severe
Please grade symptoms on a scale of 1-4: Spring summer fall winter
Are symptoms worse in the morning upon awakening?
Triggers for nasal/sinus/ear/throat: (Please circle)

Grass	weeds	trees	cat	dog	dust
Mold/mildew:	raking leaves		air conditioning		basement
Weather:	cold	heat	wind	smog	
Chemicals:	paint	perfume	soaps/detergents		cosmetics
	aerosols	smoke	wool		
	exercise	pregnancy/menstruation			Foods: (please list)

How many sinus infections in the past year? _____ Ear infection? ____ Throat infections?

Chest symptoms (cough, wheezing, congestion, breathing difficulty, etc.):
How long has the patient had chest symptoms? ____months____years episodic/constant
If episodic:
Duration of typical episode_____days
Frequency of episodes_____/month or _____/year or unpredictable
Treatment given: breathing treatment-name of medication_____
Oral steroids (Orapred/Pediapred/Prednisone)?
Antibiotics-name? _____
If constant:
How many times does the patient have cough/wheezing/shortness of breath?
Daytime-Daily/2-6 times a week/less than once a week
Nighttime--less than 2 x month / 2 x month / more than 2 x month
How often do you use rescue inhaler (puffer) –daily / 2-6 times a week / less than 1 time a week

How many ER/Urgent doctor visits for asthma in the past 6 months?

Ever hospitalized or admitted to intensive care unit for asthma? If yes, please explain…

Triggers for cough, wheezing, breathing difficulty: (please circle):
Upper respiratory infections (head colds/sinus infections)

Grass	weeds	trees	cat	dog	dust
Mold/mildew:	raking leaves		air conditioning		basement
Weather:	cold	heat	wind	smog	
Chemicals:	paint	perfume	soaps/detergents		cosmetics
	aerosols	smoke	wool		
pregnancy/menstruation		Foods: (please list):			

Does patient have recurrent bronchitis/croup/asthma/reactive airway disease/pneumonia?
Does patient have prolonged chest congestion following a virus/cold? Yes no
Does patient have exercise-induced cough, wheezing or shortness of breath? Yes no

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

Eczema:

At what age did eczema start?

Location: scalp face chest abdomen back arms legs

Triggers: (circle)

Seasonal: spring summer fall winter
Soap/shampoo/woolen clothing/jeans
Foods: (please specify)

Hives:

How long has the patient had hives?

Location: scalp face neck chest abdomen back arms legs

Itching: mild moderate severe
Is itching worse at night?

Does the rash (hives) come and go, keep moving or persist in one sot for m ore than 24 hours?

Any burning/pain or bruising at the site of the rash (hives)?

Lip swelling, tongue swelling, throat swelling, breathing problems associated with hives?

Triggers: (circle)
Soap/shampoo/woolen clothing/cosmetics/detergents/conditioners
Pressure areas: belt line, bra line, tight socks?
Heat, exercise, sweating, cold exposure, sun, pressure, vibration?
Medication: aspirin, Motrin, Aleve, and other pain relievers of the NSAID family

Foods: please list any foods, dyes, wine, MSG, that may be thought to cause hives.

Bee Sting Allergy:
When did the reaction(s) occur?
Describe the setting:
Describe the symptoms:

- Local swelling or
- Generalized hives, eyelid swelling, lip and tongue swelling, throat swelling, Breathing problems, dizziness or loss of consciousness

Food or medication allergy:
For each of the foods or medication suspected of causing a reaction, list the date when the reaction occurred, symptoms during the reaction and how long it took to resolve.

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

Respiratory Allergy Questionnaire

Nasal/sinus/ear/throat symptoms:
Severity of nasal/sinus symptoms: mild / moderate / severe
Please grade symptoms on a scale of 1-4: Spring summer fall winter
Are symptoms worse in the morning upon awakening?
Triggers for nasal/sinus/ear/throat: (Please circle)

Grass	weeds	trees	cat	dog	dust
Mold/mildew:	raking leaves		air conditioning		basement
Weather:	cold	heat	wind	smog	
Chemicals:	paint	perfume	soaps/detergents		cosmetics
	aerosols	smoke	wool		
	exercise	pregnancy/menstruation			Foods: (please list)

How many sinus infections in the past year? _____ Ear infection? ____ Throat infections?

Chest symptoms (cough, wheezing, congestion, breathing difficulty, etc.):
How long has the patient had chest symptoms? ____months____years episodic/constant
If episodic:
Duration of typical episode_____days
Frequency of episodes_____/month or _____/year or unpredictable
Treatment given: breathing treatment-name of medication_____
Oral steroids (Orapred/Pediapred/Prednisone)?
Antibiotics-name? _____
If constant:
How many times does the patient have cough/wheezing/shortness of breath?
Daytime-Daily/2-6 times a week/less than once a week
Nighttime--less than 2 x month / 2 x month / more than 2 x month
How often do you use rescue inhaler (puffer) –daily / 2-6 times a week / less than 1 time a week

How many ER/Urgent doctor visits for asthma in the past 6 months?

Ever hospitalized or admitted to intensive care unit for asthma? If yes, please explain…

Triggers for cough, wheezing, breathing difficulty: (please circle):
Upper respiratory infections (head colds/sinus infections)

Grass	weeds	trees	cat	dog	dust
Mold/mildew:	raking leaves		air conditioning		basement
Weather:	cold	heat	wind	smog	
Chemicals:	paint	perfume	soaps/detergents		cosmetics
	aerosols	smoke	wool		
pregnancy/menstruation		Foods: (please list):			

Does patient have recurrent bronchitis/croup/asthma/reactive airway disease/pneumonia?
Does patient have prolonged chest congestion following a virus/cold? Yes no
Does patient have exercise-induced cough, wheezing or shortness of breath? Yes no

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

Eczema:

At what age did eczema start?

Location: scalp face chest abdomen back arms legs

Triggers: (circle)

Seasonal: spring summer fall winter
Soap/shampoo/woolen clothing/jeans
Foods: (please specify)

Hives:

How long has the patient had hives?

Location: scalp face neck chest abdomen back arms legs

Itching: mild moderate severe
Is itching worse at night?

Does the rash (hives) come and go, keep moving or persist in one sot for m ore than 24 hours?

Any burning/pain or bruising at the site of the rash (hives)?

Lip swelling, tongue swelling, throat swelling, breathing problems associated with hives?

Triggers: (circle)
Soap/shampoo/woolen clothing/cosmetics/detergents/conditioners
Pressure areas: belt line, bra line, tight socks?
Heat, exercise, sweating, cold exposure, sun, pressure, vibration?
Medication: aspirin, Motrin, Aleve, and other pain relievers of the NSAID family

Foods: please list any foods, dyes, wine, MSG, that may be thought to cause hives.

Bee Sting Allergy:
When did the reaction(s) occur?
Describe the setting:
Describe the symptoms:

- Local swelling or
- Generalized hives, eyelid swelling, lip and tongue swelling, throat swelling, Breathing problems, dizziness or loss of consciousness

Food or medication allergy:
For each of the foods or medication suspected of causing a reaction, list the date when the reaction occurred, symptoms during the reaction and how long it took to resolve.

Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

For Office use only:

HPI: Any nursing comments

Vitals: Temp_____ HR_____ RR_____ B/P_____ Ht_____ Wt_____

Nasal: Turbinates mild / moderate / severe pale / normal clear / yellow / blood
Eyes: injected
Skin: Rash

Skin Test: Prick / #1 ID's / # 2 ID's

PFT
IT paperwork:

Discharge Instructions:

New Medications:	Sample	Technique
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergen Avoidance:
Smoking Cessation instructions:

Emla Instructions:

Chart Notes:
Diagnosis:

Meds d/c

Follow up _____ wks _____ Months Plan for follow up: PFT/Pricks/ID's

CC:

Time: