Center for Allergy and Asthma Care
250 Cetronia Road, Suite 103
Allentown, PA 18104
610-841-3890

Dear New Patient:

Enclosed please find a new patient questionnaire, information sheet and directions to our office. The building does have free valet parking. Please bring any insurance cards with you at your appointment, as we will need to scan them. Also, we will need the date of birth and the employer for the insured. If your insurance requires a referral, please make sure we have one prior to your appointment (FAX#: 610-841-3899).

Your new patient visit could take up to three hours. You need to be off of any antihistamines for five days prior to coming into our office. You should also not have any fresh sunburn on you arms or back. You should not apply any creams, lotions or perfume on either your arms or back. Excess amounts of hair should be removed from your back.

At the time of your new patient appointment, you will meet with our physician for a consultation and he/she will get a brief history form you. **Please bring a list of all your current medications or bring your meds in their containers with you to this appointment.** If you have had any previous allergy testing, either get these records and bring them with your or have them faxed to us at 610-841-3899.

All Highmark Blue Shield and Capital Blue Cross insurances, including Keystone Health Plan Central, have a maximum benefit of tests they allow yearly. The history you give our doctor will determine how much testing will be required. If we need to do more than the allotted testing (this occurs infrequently), you will be responsible for these charges along with any copays at the time of your checkout. For your convenience, we accept Master Card, Visa, check, cash or money orders.

Because of the length of this appointment, we will bill a missed appointment charge of $100.00 for an appointments not cancelled within 24 hours and no shows. We ask that you arrive with your completed paperwork, insurance cards and copay 15 minutes prior to your scheduled appointment. We do reserve the right to reschedule your appointment if you are more than 15 minutes late.

School forms: As of January 2015, all school forms will be $10.00 payable upfront. Each medication requires a separate form and parents should only fill out personal information and signature-no medical information. Forms will require 2 weeks for completion- No exceptions-plan ahead.

We will call you several days prior to your appointment if you have any questions and to confirm this appointment. If we do not reach you, you will be asked to call and confirm this time slot because of the length of the appointment.

If you have any questions, please call our office at 610-841-3890.

Thank you.

Center for Allergy and Asthma Care
Patient Information Sheet

Please Print

FULL NAME:____
SEX: Male / Female DOB: __________________
ADDRESS: ____
PHONE (Home):______________________PHONE (Work):________________________
PHONE (Cell):________________________

PARENTS, If Patient is a Child,
MOTHER'S NAME: ___________________________PHONE:______________________
FATHER'S NAME: ___________________________ PHONE:______________________
E-MAIL______________________________________ TEXTING ALLOWED YES/NO

RACIAL STATUS (Please Circle):
White Black/African American Hispanic Other
American Indian Alaskan Native Asian/Pacific Islander Unknown

EMERGENCY CONTACT: __________________________PHONE:_______________

PHARMACY: ___________________________LOCATION:_______________________

FAMILY DOCTOR OR PEDIATRICIAN: (Name Specific)
____
LOCATION, IF MORE THAN ONE OFFICE:
____
REFERRING DOCTOR, IF DIFFERENT:
____

INSURANCE INFORMATION:
PLEASE BRING YOUR CARD AND THIS FORM TO THE FRONT DESK. IF THE INSURANCE IS NOT IN YOUR NAME, PLEASE FILL IN BELOW:

SUBSCRIBER NAME:___________________________SEX : Male/Female
SUBSCRIBER DOB:_____________________________
SUBSCRIBER PLACE OF EMPLOYMENT:___________________________________

Center for Allergy and Asthma Care
ALLERGY QUESTIONNAIRE

NAME____________________________________DOB:_________________

How did you hear about us?
____

What are the reasons for your visit?
____
____
____
____

What goals do you wish to accomplish with the allergist?
____
____

Do symptoms involve your:

	YES	NO
eyes	____	____
ears	____	____
nose	____	____
throat	____	____
chest/lungs	____	____
digestive system	____	____
skin	____	____

When do symptoms occur:

year round	____	____
spring	____	____
summer	____	____
fall	____	____
winter	____	____
intermittent	____	____

Do you have any food reactions? Yes ____ No_____
If yes, which foods and what type of reactions?
____
____
____

What types of exposures trigger your symptoms?

	YES	NO	UNSURE
mowing the lawn	____	____	_________
raking leaves	____	____	_________
dusting or vacuuming	____	____	_________
pets	____	____	_________
exercise	____	____	_________
cold air	____	____	_________
strong odors or perfumes	____	____	_________
smoke	____	____	_________
after a cold	____	____	_________
bee sting	____	____	_________

Is there anyone in your family with allergies or asthma? Yes______ No_____
If yes, which relatives and what problems do they have?__________________________
____
____
____

ENVIRONMENT:
Is there carpeting in your house, which rooms?
____

If you have a basement, do you spend time there? Yes_____ No_____
Is the basement damp or musty? Yes_____ No_____

Are there allergy encasings on any bedding? Yes_____ No_____

Approximate age of mattress________

Are pets allowed in the bedroom? Yes______ No_______
Do they sleep in the bedroom? Yes______No ______
Do they sleep on the bed? Yes _____ No _____

Does anyone in the household smoke, and if so, where do they smoke?
____
What type of heating and air conditioning is in the home?
____

ANTIHISTAMINE LISTING

ABILIFY	CHERACOL PLUS	DURADRYL SYRUP
ACCUHIST LA	CHLOR-TRIMETON (CHLORPHENIRAMINE MALEATE)	DURAHIST
ACCUHIST DA, PED DROPS	CHLOR-TRIMETON DECONGESTANT	DURATAN
ACTIFED	CLARINEX	DURATAP
ADAPIN	CLARITIN, CLARITIN-D, CLARITIN SYRUP, CLARITIN REDITAB	DURATAP PD
ADVIL ALLERGY SINUS	CLEMASTINE	DURAVENT/DA
ADVIL PM		DYMISTA
AEROHIST	CLESTAT	EFIDAC 24 CHLORPHENIRAMINE
AEROKID SYRUP	CLOZAPINE	ELAVIL (AMITRIPTYLINE HCL)
ALAVERT	CODIMAL	ELESTAT
ALKA-SELTZER COLD MEDICINE	COMHIST LA	ENDAL PLUS HD
ALLEGRA (FEXOFENADINE)	COMTREX	ETRAFON FORTE
ALLEGRA D	CONGESPIRIN	EXTENDRYL JR. AND SR.
ALLER DUR	CONTAC	EXTENDRYL CHEWABLES
ALLEREST	CORICIDIN	EXTRENDRYL SYRUP
ALLENT	CO-PYRONIL	FAZACLO
ALLERX DOSE PAK (BLUE PILL)	CO-TYLENOL	FEDAHIST GYROCAPS
AMITRIPTYLINE HCL (ELAVIL)	DA II	FEXOFENADINE
ANAMINE	DA CHEWABLES	GEODON
ANTIVERT (MECLIZINE)	DECONAMINE	HISTALET FORTE
ASENDIN	DEMAZIN	HISTAVENT
ASTELIN NASAL SPRAY	DIMETAPP	HISTEX SR.
ASTEPRO (GENERIC AZELASTINE)	DIMETANE (BROMPHENTRAMINE MALEATE)	HISTEX HC
ATARAX (HYDROXYZINE)	DIMETANE DECONGESTANT	HISTEX PD
ATROHIST		HYCOMINE COMPOUND
AXID	DISOPHROL	HYDROXYZINE (ATARAX)
BENADRYL (DIPHENHYDRAMINE HCL)	DORCOL	ISOCLOR
BIOHIST LA	DOXEPIN (SINEQUAN)	KRONOFED-A
BROMFED	DOXYLAMINE	KRONOFED-A-JR.
BROMFED PD	DRISTAN	LEVOCETIRIZINE (GENERIC XYZAL)
BROMFENEX	DRIXORAL	LIMBITROL DS
BROMPHENIRAMINE	DRIZE	LORATADINE (GENERIC CLARITIN)
MARAX	RELCOF CPM	TAVIST (CLEMASTINE FURMARATE)
MECLIZINE	REMERON	TAVIST-1 (CLEMASTINE FURMARATE)
NALDECON (CHECK LABEL)	RISPERDAL	TAVIST D
NO HIST/NO HIST PLUS/NO HIST PLUS JR./NO HIST EXT.	ROBITUSSIN NIGHT RELIEF	TELDRIN
NOLAHIST (PHENINDAMINE TARTRATE)	RONDEC	THERAFLU, FLU & COLD MEDICINE

NOLAMINE	RONDEC DM	TIMEHIST QD
NORPRAMIN (DESIPRAMINE)	R-TANNATE	TOFRANIL (IMIPRAMINE HYDROCHLORIDE)
NOVAFED A	RU-TUSS	TRIAMINIC
NOVAHISTINE ELIXIR	RU-TUSS II	TRIAMINIC TR
NYQUIL	RYNA-12	TRIAMINIC-12
OPTIMINE (AZATADINE MALEATE)	RYNA-LIQUID	TRIAVIL
OPTIVAR	RYNATAN (MOORETAN)	TRITEC
ORNADE	RYNATUSS	TRINALIN
ORNEX	SCOT-TUSSIN	TUSSI-12S
PBZ (TRIPELENNAMINE HYDROCHLORIDE)	SEMPREX	TUSSI-12
PALGIC	SEROQUEL	TUSSIONEX PENNKINETIC EXTENDED-RELEASED SUSPENSION
PAMELOR (NORTRIPTYLINE HCL)	SINAREST	TYLENOL COLD/PLUS/MULTISYMPTON
PATADAY	SINE-OFF	TYLENOL PM
PATANASE	SINEQUAN (DOXEPIN)	VICKS FORMULA
PATANOL	SINULIN	VIVACTIL
PEDIACARE (CHECK LABEL)	SINUTAB	VIRAVAN
PEPCID (FAMOTIDINE)	SUDAFED PLUS	VIRAVAN DM
PERIACTIN (CYPROHEPTADINE)	SURMONTIL	VISINE A
PHENERGAN (PROMETHAZINE)	SYMBYAX	VISTARIL
PHENYLCHLORTAN	TACARYL (METHDILARINE)	XYZAL (LEVOCETIRIZINE)
POLARAMINE (DEXACHLORPHENIRAMINE MALEATE)	TAGAMET (CIMETIDINE HCL)	ZADITOR
POLYHISTINE	TANAFED	ZANTAC (RANITIDINE HYDROCHLORIDE)
PYRROXATE	TANAFED DM	ZYRTEC (CETIRIZINE HCL)
REDRYLEX	TANDUR DM	ZYRTEC D

2-20-18

DIRECTIONS TO:

CENTER for ALLERGY and ASTHMA CARE
250 CETRONIA ROAD, SUITE 103
ALLENTOWN, PENNSYLVANIA 18104
PHONE: 610-841-3890

FROM: ROUTE 22, EITHER DIRECTION, TAKE ROUTE 309 SOUTH TO TILGHMAN STREET WEST EXIT (FIRST EXIT AFTER GETTING ON ROUTE 309). FIRST TRAFFIC LIGHT (HAUSMAN ROAD/CETRONIA ROAD)– TURN LEFT ONTO CETRONIA ROAD AND GO THREE TRAFFIC LIGHTS TO OUR COMPLEX. MAKE A RIGHT AND FOLLOW CIRCLE TO STOP SIGN. TURN LEFT AND COME ACROSS THE FRONT ENTRANCE TO THE BUILDING. YOU MAY USE EITHER FREE VALET PARKING OR PARK TO THE LEFT OF THE BUILDING AND WALK UP. WE ARE ON THE FIRST FLOOR, SUITE 103. (COME IN FRONT DOOR AND BEAR LEFT –STRAIGHT BACK)

FROM: POINTS NORTH, TAKE CEDAR CREST BOULEVARD DOWN TO TILGHMAN STREET, MAKE A RIGHT AND CONTINUE ON TILGHMAN UNTIL YOU GO UNDER ROUTE 309 AND AT JOSH EARLY CANDIES (FIRST TRAFFIC LIGHT AFTER ROUTE 309) (HAUSMAN ROAD/CETRONIA ROAD) MAKE A LEFT ONTO CETRONIA ROAD AND GO THREE TRAFFIC LIGHTS TO COMPLEX. MAKE A RIGHT AND FOLLOW CIRCLE TO STOP SIGN. TURN LEFT AND COME ACROSS THE FRONT ENTRANCE TO THE BUILDING. YOU MAY USE EITHER FREE VALET PARKING OR PARK TO THE LEFT OF THE BUILDING AND WALK UP. WE ARE ON THE FIRST FLOOR, SUITE 103. (COME IN FRONT DOOR AND BEAR LEFT – STRAIGHT BACK)

IF YOU ARE TRAVELING ROUTE 78 WEST - GO TO ROUTE 309 NORTH TO TILGHMAN STREET WEST. ON THE FIRST TRAFFIC LIGHT (HAUSMAN ROAD/ CETRONIA ROAD) – TURN LEFT ONTO CETRONIA ROAD AND GO THREE TRAFFIC LIGHTS TO OUR COMPLEX. MAKE A RIGHT AND FOLLOW CIRCLE TO STOP SIGN. TURN LEFT AND COME ACROSS THE FRONT ENTRANCE TO THE BUILDING. YOU MAY USE EITHER FREE VALET PARKING OR PARK TO THE LEFT OF THE BUILDING AND WALK UP. WE ARE ON THE FIRST FLOOR, SUITE 103. (COME IN FRONT DOOR AND BEAR LEFT – STRAIGHT BACK)

IF YOU ARE TRAVELING ROUTE 78 EAST – GO TO ROUTE 22 EAST TO ROUTE 309 SOUTH AND GET OFF AT TILGHMAN STREET WEST. FIRST TRAFFIC LIGHT (HAUSMAN ROAD/CETRONIA ROAD) – TURN LEFT ONTO CETRONIA ROAD AND GO THREE TRAFFIC LIGHTS TO OUR COMPLEX. MAKE A RIGHT AND FOLLOW CIRCLE TO STOP SIGN. TURN LEFT AND COME ACROSS THE FRONT ENTRANCE TO THE BUILDING. YOU MAY USE EITHER FREE VALET PARKING OR PARK TO THE LEFT OF THE BUILDING AND WALK UP. WE ARE ON THE FIRST FLOOR, SUITE 103. (COME IN FRONT DOOR AND BEAR LEFT – STRAIGHT BACK)