allergy asthma
Consultants of Fairfield County

Aimee Altschul-Latzman, M.D.
ADULT & PEDIATRIC ALLERGY, ASTHMA & IMMUNOLOGY

Personal Information		Allergies to Medicine	
Name:		Allergic To	Describe Reaction
Address:			
Birth Date:			
Primary Care Physician	Name:	Phone #:	

List all medicine you are currently taking: Prescription and over-the–counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers, nitroglycerin).

Prescription Medication Name	Dose (How much)	Frequency (How often)

Over-the-Counter Medications/Vitamins/Herbals		
Name of Medication	Dose (How much)	Frequency (How often)

Medication List Completed or Updated (Date): _____ **Page** _____ **of** _____

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PATIENT INFORMATION

Social Security #: _____

Last Name: _____ First: _____ MI: ____

Address: _____

City, State, Zip Code: _____

Home Phone #: _____

Cell Phone #: _____

Date of Birth: _____ **Sex:** ❑ M ❑ F

Marital Status:
❑ Single ❑ Married ❑ Widow ❑ Divorced ❑ Legally Separated

Name of Spouse: _____

Spouse Phone #: _____

Email Address: _____@_____

****Ethnicity:** ❑ Hispanic ❑ Non - Hispanic

****Preferred Language:** _____

****RACE:** _____

Name of Pharmacy: _____

Phone #: _____

Town: _____

Name of Employer: _____

Position: _____

Address: _____

City, State: _____

Zip Code: _____ Phone #: _____

PHYSICIAN REFERRAL INFORMATION

Primary M.D. _____ Referred By _____

Phone # _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ❑ SELF (**skip to next section**) ❑ Parent ❑ Spouse ❑ Employer ❑ Other:

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Name of Employer: _____ Work #: _____

Employer Address: _____ City, State, Zip: _____

INSURANCE/POLICY HOLDER INFORMATION

Name of Primary Insurance: _____

ID #: _____ Effective Date: _____ Copay: _____

Policy Holders Relationship to Patient: ❑ SELF (**skip to next section**) ❑ Parent ❑ Spouse ❑ Employer ❑ Other:

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INSURANCE/POLICY HOLDER INFORMATION (CONTINUED)

Policy Holder Last Name: _____ Policy Holder First Name: _____

Policy Holder Date of Birth: _____ Name of Employer : _____

Address: _____ Employer Address: _____

Phone #: _____ City, State, Zip: _____

Name of Secondary Insurance: _____

ID #: _____ Effective Date: _____ Copay: _____

Policy Holders Relationship to Patient: ❑ SELF (**skip to next section**) ❑ Parent ❑ Spouse ❑ Employer ❑ Other:

Policy Holder Last Name: _____ Policy Holder First Name: _____

Policy Holder Date of Birth: _____ Name of Employer : _____

Address: _____ Employer Address: _____

Phone #: _____ City, State, Zip: _____

AUTHORIZATION & SIGNATURE SECTION

****AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I hereby give authorization for performance of medical treatment or procedure as may, in the judgment of my attending physician, be deemed necessary. I authorize the office of Allergy & Asthma Consultants of Fairfield County to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. **I recognize and accept responsibility for the services rendered regardless of insurance coverage.** This includes but is not limited to co-insurance, co-payment, deductible, and non-covered services.

y attending
required during
es rendered. I
es but is not

Date: _____ **X Signature:** _____

****PATIENT AGREEMENT

I agree to pay you your regular charges for medical services rendered. My health insurance benefits may pay all or part of your charges. **I agree to pay those charges which are not paid by my health insurance. If I do not pay your bill, I agree to pay you your collection costs including attorney's fees and court costs** (there will be a $20 charge for all returned checks).

Date: _____ **X Signature:** _____

****MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Allergy & Asthma Consultants of Fairfield County for any services furnished to me by the physician or supplier. **I authorize any holder of medical information about me to release to the Health Care Financing Administration** and its agents any information needed to determine these benefits or the benefits payables for related services.

Date: _____ **X Signature:** _____

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CONFIDENTIAL COMMUNICATION

***** Please provide preferred method of communication *****

I hereby request the following means of communication related to my personal health, treatment, diagnosis, test results or billing as noted below:

I prefer to be contacted by: Please circle **(Y) yes or (N) no**

Home Phone: **Y / N** _____ • Cell Phone: **Y / N** _____ • Work phone: **Y / N** _____ • U.S. Mail: **Y / N** _____

If more than one YES**, please list preferences in order 1-4 in the space provided next to **Y/N.

EMERGENCY CONTACT INFORMATION

Name **Relationship** **Phone**

1. _____
2. _____

HIPAA AUTHORIZATION TO DISCLOSE

I give permission to disclose my personal health information, treatment, diagnosis, test results or billing with:

Name **Relationship** **Phone**

☐ *Check here if you choose the same person(s) as your emergency contact.* ***Please sign** and skip to the next section*

1. _____
2. _____
3. _____

_____

Patient Signature **Printed Name** **Date**

DISCLAIMER

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Allergy & Asthma Consultants of Fairfield County 140 Sherman St 3rd Floor Fairfield, CT 06824. I understand that a revocation is not effective to the extent that Allergy & Asthma Consultants of Fairfield County has relied on the use or disclosure of the protected health information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices from Allergy & Asthma Consultants of Fairfield County. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the practice has reserved a right to change its privacy practices that are described in the notice.

_____

Patient Signature **Printed Name** **Date**

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Acknowledgement of Financial Responsibility

Date: _____

Patient: _____

Before you make a decision, check with your insurance benefits department. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these services, knowing you may be responsible for payment.

I, _____, authorize the performance of the following test(s)

- ☐ **95004** Skin testing, percutaneous
- ☐ **95024** Skin testing, intradermal

To be performed by Dr. Aimee Altschul-Latzman and associates as deemed necessary.

The results that may be obtained from these tests have not been guaranteed.

_____
Patient/Guardian Signature

140 Sherman Street • Fairfield, Connecticut 06824 • Ph 203.955.1461 • Fax 203.955.1464