Eric W. Bantz, MD and **John Y. Kim, MD**
Diplomates, American Board of Allergy and Immunology
103 Old Marlton Pike Suite 211
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TEL (609) 953-7500 // FAX (609) 953-9085

Dear New Patient:

Welcome to our practice! We consider it a privilege that you have selected our practice and thank you for allowing us to serve your health care needs. We invite you to visit our website at **www.cornerstoneallergy.com**. The following information is provided to introduce you to our practice and our practice policies.

We are enclosing our new patient information forms for you with this letter. Please complete the forms and bring them with you to your first appointment to help speed up the check in process. We ask that you arrive 15 minutes prior to your appointment time, so that we may get all your paperwork together and set up your chart to be ready for your appointment time.

LOCATION AND HOURS: We have office hours **Monday:** 8:30 – 11:30 am & 2:00 – 7:00 pm; **Tuesday:** 8:30 – 11:30 am & 2:00 – 4:30 pm; **Wednesday:** 2:00 pm – 7:00 pm; **Thursday:** 8:30 – 11:30 am & 2:00 – 4:30 pm; **Friday:** 8:30 – 11:30 am & 1:30 – 3:30 pm; **Sat:** 8:30 am – 11:30 am. Please remember to bring any referrals that are required. Patients that arrive more than 10 minutes late for an appointment may be asked to reschedule. We request that you give us at least 24-hour notice if you are unable to keep a scheduled appointment. This will give us time to schedule someone else who may have an urgent need for care.
According to office policy, if you fail to keep or cancel your first new patient appointment, in advance, you will not be rescheduled. If you do not show up to your appointment without notifying the office ahead of time you will be charged a $25 fee. Additionally, if you fail to notify us in advance and do not show for 3 scheduled appointments, you will be dismissed from the practice.

FINANCIAL: If you have medical insurance, please bring all of your current insurance identification cards with you to the appointment. Please check to make sure that the cards are not expired. You will also need to bring a valid photo identification card.

It is necessary for you to bring any co-payments you will owe, according to your insurance benefits, to your office visit and it will be collected at the time of check-in. For self pay patients, payment in full at the time of service is required. We accept cash, checks, money orders, traveler's checks, and all major credit cards. There is a $25.00 insufficient (bounced check) fee if your check does not clear the bank, in addition to the amount of your check.

The physicians and staff respectfully request that you turn off your cell phone when in our office. Thank you! We look forward to meeting you soon!

Dr. Eric Bantz & Dr. John Kim

Cornerstone Asthma & Allergy Associates, LLC

REGISTRATION FORM

Patient Name: _____ **DOB**: _____ **SSN**: _____

Address: _____ **City/State/Zip**: _____

Phone (#1): _____ **(#2)**: _____ **(Work)**: _____

Email: _____ **Gender**: Male Female **Marital Status**: Single Married Divorced Widow

Emergency Contact: _____ Contact #: _____ Relation: _____

Primary Physician Name: _____ **Practice**: _____

Primary Physician Address: _____ **Phone**: _____

Request a follow-up letter sent to your family doctor: YES NO

List Family Member(s) if our patient: _____

How did you hear about us: Friend Family Online Primary Physician Other:_____

INSURANCE INFORMATION

Primary Health Insurance Company: _____

Guarantor Name: _____ **Home Tel**.: _____ **Cell**: _____

DOB: _____ **SSN**: _____ **Relationship to Patient**: _____

Primary Insurance Guarantor's Address: _____

Secondary Health Insurance Company: _____

Guarantor Name: _____ Home Tel.: _____ Cell: _____

DOB: _____ SSN: _____ Relationship to Patient: _____

Secondary Insurance Guarantor's Address: _____

I request payment of authorized benefits be made to Cornerstone Asthma & Allergy Assoc., LLC for professional services rendered to me. I will 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 benefit payments for related services. I understand that I will be responsible for any balance my insurance company does not cover. I have had the opportunity to review a copy of Cornerstone Asthma & Allergy Assoc., LLC (the Practice's) notice of privacy practices* (HIPAA: Health Insurance Portability and Accountability Act). I agree, in order for you to serve my account or to collect monies I may owe, Cornerstone Asthma and Allergy Associates and/or your agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. You may also contact me by sending text messages or emails, using any email address I provide to you. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I give permission to Cornerstone Asthma & Allergy Assoc., LLC to leave messages on my answering machine or voice mail. I/we have read the disclosures above and agree that Cornerstone Asthma and Allergy Associates, its employees and/or agents may contact me/us as described above.

Please read the above and acknowledge with signature:

Patient/Parent/Guardian Signature: _____ Date: _____

** Clinic's Notice of Privacy Practices can be requested at our front desk.*

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NEW PATIENT INTAKE FORMS

Please answer ALL the following questions as completely and accurately as possible.

Name	Age	Birth Date	Appointment Date
Occupation (please describe)			
Days missed work or school/year	Hobbies		
When and where did your allergy symptoms start? Year State		How long have you lived in New Jersey:	
BRIEFLY DESCRIBE REASON FOR VISIT_____			

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

Circle or check items that apply and place an **X** under "No" if you have not suffered the symptom or if it does not apply.

Present Problem	**Past Problem**	NO	**CONDITION or SYMPTOM** (circle words that apply)	Age at Onset	Factors that may increase these symptoms: animals, chemicals, dust, drugs, foods, infections, smoke, odors, weather, etc.
			Hay Fever (itchy nose, sneezing, congestion, runny nose, stuffy nose, post nasal drip)		WORSENS: Spring? Summer? Fall? Winter?
			Anaphylaxis		
			Eye Allergy Problems		
			Headaches Migraines		
			Frequent Ear Infections		
			Chronic ear: crackling - popping - pressure		
			Sinus Disease or Sinus Infections		
			Asthma, wheezing, coughing, short of breath		
			Bronchitis How many in the last 3 years?		
			Pneumonia Dates		
			Immune Defect-Frequent or Recurrent Infections		
			Insect Allergies (full details next page)		
			Hives - Urticaria		
			Allergy type swelling - Angioedema		
			Eczema or other rashes		
			Food Allergies Type of reaction?		
			Reaction to latex, rubber, or elastic		
			Reaction to make-up, skin care products, hair dye		
			Reaction to jewelry or metals		

_____
Nurse Initials

Reviewed & agree _____
EWB JYK

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List MEDICAL and SURGICAL History: _____

_____

_____

_____

_____

Current Medications: List or attach all medications (Prescription and Over the Counter) taken routinely or on an as needed basis. Include any of the following: Aspirin, Advil, Tylenol, antacids, laxatives, vitamins & herbal products, sleeping pills, nose drops, eye-drops and all pills you take on a daily basis.

Medication	Dosage & Directions	Date Started	Doctor or Nurse Notes
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Past Medications used for Allergy and Asthma (include oral and topical corticosteroids, antihistamines, and nose sprays and inhalers)

Medication	Dosage & Directions	How well did it work?	Any Side Effects?
		None Partial Great	
		None Partial Great	
		None Partial Great	

Drug Allergy or Intolerance

Medication	Reaction Year	Describe symptoms

Insect Allergy Bees, fire ant, hornet, yellow jacket, wasp, etc.

Insect if known	Date	Describe symptoms	Describe treatment required

Hospitalizations or ER visits in the past 5 years?

Reason	Date	Reason for treatment	Hospital (Name & Address)

_____
Nurse Initials

Reviewed & agree _____
EWB JYK

NAME: _____

DOB: _____

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Previous Allergist ☐ No ☐Yes	Address	phone
Skin or Blood Tests? ☐ No ☐Yes	List any positive results:	
Did you receive allergy shots? ☐ No ☐Yes	Treatment dates	
ENT Doctor ☐ No ☐Yes	Address	phone
Ear, nose or throat surgery? ☐ No ☐ Yes	List procedures & year:	
Specialist (GI, Pulmonary, Dermatology?)	Address	phone

Procedures

Have you ever had any of the following?	When and Where?	Results?
Pulmonary Function ☐No ☐Yes		
Sinus CT ☐No ☐Yes		
Chest X-ray ☐No ☐Yes		
TB test ☐No ☐Yes		
Other:		

Home Environment

Type of home _____ Approximate home age _____ Any obvious mold growth or roof leaks? ☐ NO ☐ YES

Describe neighborhood (major plants, near horses, cows, wooded, lake):_____

Basement: ☐ NO ☐ YES If so, damp/flooded? ☐ NO ☐ YES // Finished? ☐ NO ☐ YES

Crawl Space: ☐ NO ☐ YES

Patient Bedroom: Carpet ☐ Hard Surface ☐ Ceiling Fan ☐ Plants ☐ Stuffed Furniture ☐ Stuffed toys on bed ☐

Air conditioning? Central ☐ Room units ☐ Routine Service? ☐ NO ☐ YES
Do you have an air cleaner? ☐ NO ☐ YES Location:
What type of pillow do you have? Feather ☐ Synthetic ☐ Other:
Comforter/Blanket? Cotton ☐ Down/Feather ☐
Age of Mattress Allergy proof encasing used? ☐ NO ☐ YES

Animal - Pet History

Are you around any animals ☐ NO ☐ YES Have you noticed any symptoms around animals? ☐ NO ☐ YES

If so, describe: _____

Do pets sleep in your bedroom? ☐ NO ☐ YES In your bed? ☐ NO ☐ YES

Type	#	Age	Inside	Outsid	In & Outside
Cat					
Dog					
Rabbit					

Type	#	Age	Inside	Outside	In & Outside
Bird					
Hamster/Gerbil					
Horse					

_____
Nurse Initials

Reviewed & agree _____
EWB JYK

NAME: _____

DOB: _____

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Personal History

Smoking exposure: Work ☐ No ☐ Yes Home ☐ No ☐ Yes
Have you ever smoked ☐ No ☐ Yes Year quit_____
Do you presently smoke? ☐ No ☐ Yes How long?_____
What? Cigarettes Cigars Pipe Average pack/day_____
If you still smoke do you think you could stop? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes Average # / week____
Allergies worse with alcohol or tobacco: ☐ No ☐ Yes
If yes, please explain: _____
_____

Review of Systems: Mark X under No if it does not apply to you, circle symptoms or diseases and describe when needed.

NO	CONDITION	Notes (include any ailments not covered)
	Constitutional: e.g. weight loss, fatigue, sleeping problems, fever, chills	
	Eye Problems: e.g. glaucoma, acute vision changes, pain, light sensitivity	
	Ear, Nose ,Throat, Mouth: recurrent infections, hoarseness, difficulty smelling, ear pain, difficulty hearing, snoring, excessive mouth breathing	
	Cardiovascular: e.g. angina, chest pain, heart attack, high blood pressure arrhythmia, skipped beats, palpitations, flutter, murmur, rheumatic fever, mitral valve prolapse	
	Respiratory: e.g. embolism, tuberculosis, coughing blood	
	GI: e.g. trouble swallowing, heartburn, reflux, frequent use of antacids nausea, vomiting, diarrhea, constipation, cramping, abdominal pain, irritable bowel syndrome, hiatal hernia, peptic ulcer, gallbladder, liver problems, hepatitis or liver inflammation	
	Genitourinary: e.g. frequency, pain on urination, blood in urine, recurrent urinary tract infections, prostate problems, slow stream of urine in men, kidney problems, cancer, hysterectomy, ovaries removed	
	Musculoskeletal: e.g. Arthritis, broken bones, osteoporosis, autoimmune disorders	
	Skin Problems: e.g. Rashes, acne, psoriasis, sunlight sensitivity	
	Neurological: e.g. headache, numbness, tingling, pain, stroke, TIA,	
	Endocrine: e.g. diabetes, thyroid disease	
	Cancer: any type and treatment received	
	Psychiatric: e.g. depression, eating disorders, anxiety, thoughts of suicide	
	Hematologic Lymphatic: e.g. anemia, enlarged lymph nodes	
	Other Ailments:	

Family Allergy History

Is there a family history of allergies? ☐ No ☐ Yes	Father	Mother	Fathers Parents	Mothers Parents	Siblings	Children
Nose or Eye Allergies						
Asthma						
Hives						
Eczema						
Food or Bee Allergies						
Immune Deficiency Disorder						
Drug Allergies						
Autoimmune Disease						

NAME: _____

DOB: _____

Thank you for taking the time and effort to fill this form as completely and accurately as possible. Your information will allow us to give you the best appropriate care possible.

Patient Name: _____

Patient Signature: _____

Guardian Signature: _____

Nurse Signature: _____

Physician / Date: _____

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Examples of Antihistamines to Avoid Prior to Allergy Testing

- Actifed
- Advil-PM
- Alavert
- Alaway
- Allegra
- Alka-Seltzer-Allergy
- Astelin
- Astepro
- Atarax
- Benadryl
- Bepreve
- Bromfed
- Cetirizine
- Chlorpheniramine
- Chlortrimeton
- Clarinex
- Claritin
- Clemastine
- Cyproheptadine
- Deconamine
- Desloratidine
- Dimetapp
- Diphenhydramine
- Doxepin
- Doxylamine
- Duradryl
- Dymista
- Epinastine
- Extendryl
- Fexofenadine
- Hydroxyzine
- Ketotifen
- Kronofed-A
- Lastacaft
- Levocetirizine
- Loratadine
- Midol
- Motrin-PM
- Nyquil
- Olopatadine
- Pamprin
- Patanase
- Pataday
- Patanol
- Pazeo
- PediaCare-Night Time
- Phenergan
- Pheniramine
- Promethazine
- Pyrilamine Maleate
- Qlearquil
- Rondec
- Rynatan
- Semprex-D
- Tavist
- Triaminic
- Tylenol-PM
- Tylenol-Cold
- Unisom
- Vistaril
- Xyzal
- Zyrtec

Please discontinue all antihistamines for 4 days prior to any allergy testing.

Please call us if you have any questions or concerns.