

**BEACHWOOD**  
24400 Highpoint #1  
Beachwood, Ohio 44122  
216-831-4930

**WESTLAKE**  
805 Columbia Rd. #106  
Westlake, Ohio 44145  
440-777-9969

**STRONGSVILLE**  
16000 Pearl Rd. #19  
Strongsville, Ohio 44149  
440-238-1304

**MENTOR**  
7200 Mentor Ave. #101  
Mentor, Ohio 44060  
440-953-8008

**PARMA**  
6681 Ridge Rd #206  
Parma, Ohio 44129  
440-843-9093

**FAIRLAWN**  
3094 W. Market #142  
Fairlawn, Ohio 44333  
330-836-9232

# ALLERGY DIAGNOSTIC SYSTEMS, INC.

Barry A. Lampl, D.O.

Please fill out the attached paperwork in full.

Your appointment is scheduled for \_\_\_\_\_ @ \_\_\_\_\_  
**WE REQUIRE 24 hr ADVANCE NOTICE OF CANCELLATIONS**

## REMINDERS:

1. **DO NOT** take anything that may contain an antihistamine after:

(i.e. Claritin, Zyrtec, Benadryl, Allegra  
reflux medications: Zantac and Pepcid  
and certain sleep aids, cold pills, cough syrups, and nasal sprays)

2. Wear a short-sleeved shirt.

3. You will be with us for approximately 1 1/2 hours.

4. Please bring your insurance card(s) in with you.

5. Please bring the names of all medications currently being taken.

If you have any questions, please phone our office @ 216-831-4930

We have contacted your insurance company. Below is the coverage information provided to us by a representative.

**\*\* DEDUCTIBLE \_\_\_\_\_**

**\*\* OFFICE CO-PAY \_\_\_\_\_  
(PLEASE PAY AT THE TIME OF YOUR OF VISIT)**

**\*\* ALLERGY TESTING, SHOTS, AND RESPIRATORY  
TESTING COVERED AT \_\_\_\_\_**

**\*\* PRE-EXISTING CLAUSES \_\_\_\_\_**

**ALLERGY DIAGNOSTIC**

**DATE** \_\_\_\_\_

**PATIENT INFORMATION**

<b>Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	<b>Suffix</b>

<b>Social Sec #</b>	<b>Date of Birth</b>	<b>Gender</b>	<b>Marital Status</b>
		Male / Female	Divorced / Married / Single / Widowed

<b>Street Address</b>	<b>Home Phone</b>

<b>Line 2</b>	<b>Work Phone</b>

<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Country</b>	<b>Cell Phone</b>

<b>Emergency Contact</b>	<b>Emergency Contact Phone</b>	<b>Best Contact for Appointment Reminder?</b>
		Home _____ Work _____ Cell Call _____ Cell Text _____

<b>Guarantor Name</b>	<b>Relationship</b>	<b>Guarantor Address, City Zip</b>	<b>Guarantor Contact Number</b>

<b>Primary Insurance Name</b>	<b>Policy Number</b>	<b>Group Number</b>	<b>Subscriber's Name/Relationship to Patient/DOB</b>	<b>Copay Amt</b>

<b>Secondary Insurance Name</b>	<b>Policy Number</b>	<b>Group Number</b>	<b>Subscriber's Name/Relationship to Patient/DOB</b>	<b>Copay Amt</b>

<b>Primary Care Doctor / Phone</b>	<b>Referred by?</b>

**How did you hear about our practice?**

<b>Doctor</b>	<b>Internet</b>	<b>Newspaper</b>	<b>Pharmacy Bag</b>	<b>Telephone</b>	<b>Friend/Relative:</b> _____
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<b>Local Pharmacy</b>	<b>Phone Number</b>	<b>Location of Pharmacy</b>	<b>Patient Email</b>

**AUTHORIZATION**

**Patient or Authorized Person's Signature Required:**

I hereby authorize Dr. Barry Lampl and his staff to submit my claims to my insurance carrier for all services and I understand that I am financially responsible for balances not covered. I authorize the release of any medical or other information necessary to process these claims. I authorize payment of medical benefits to the above physicians for services provided.

\_\_\_\_\_ **Date:** \_\_\_\_\_  
**SIGNATURE OF PATIENT OR LEGAL GUARDIAN**

# ALLERGY DIAGNOSTIC SYSTEMS, INC.

Barry A. Lampl, D.O.

**HISTORY SHEET** Name: \_\_\_\_\_

Sex: M / F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

YES	NO	ANIMALS-EXPOSURE
		Cat
		Dog
		Bird
		Horse
		Other

YES	NO	SKIN
		Eczema
		Hives

FAMILY HISTORY				
	Age	Hayfever	Asthma	Sinusitis
Mother				
Father				
Brother				
Brother				
Sister				
Sister				

YES	NO	LIVING ACCOMMODATIONS
		House
		Apartment
		Basement- damp / dry / carpet / furniture
		Bedding- conventional mattress / waterbed
		Bedroom- carpeting / hardwood

YES	NO	HEATING AND COOLING
		Air Conditioner- central / window
		Furnace- gas / electric / wood burning

YES	NO	MONTHS YOU HAVE SYMPTOMS
		All Months
		January
		February
		March
		April
		May
		June
		July
		August
		September
		October
		November
		December

OTHER	
Asthma	Diabetic
Nasal Polyps	Heart Disease
Deviated Septum	Glaucoma/Cataracts
Broken Nose	Beta Blocker Medication
Sinus Disease	Cortisone
Pneumonia	Learning Difficulty
Emphysema	ADHD/Hyperactivity
Nasal/Sinus Surgery	Smoker
Frequent Headaches	Fatigue
High Blood Pressure	Prior Allergy Shots
Stomach Disease	Prior Allergy Testing

Name \_\_\_\_\_ Date \_\_\_\_\_

**Allergy and Asthma Symptom Score Questionnaire**

Have you missed any school/work due to respiratory problems in the last month? **YES NO**

Have you been to any physicians or emergency rooms since your last visit on \_\_\_\_\_?

Have you been prescribed any new medications since your last visit? **YES NO** If yes, please list \_\_\_\_\_

Are you currently taking Blood Pressure Medication? **YES NO**

If Yes, which medication? \_\_\_\_\_

Do you have an up to date Epipen? **YES NO**

If you use a rescue inhaler, how frequently are you using it? \_\_\_\_\_

Mark an X on the scale at the location you think corresponds to the importance of your symptoms.

	None	Trivial	Mild	Moderate	Severe
<b>EYES</b>					
Itching					
Swelling					
Watery discharge					
<b>NOSE</b>					
Itching					
Sensation of fullness, congestion, blockage					
Sneezing					
Discharge or runny nose					
<b>EARS</b>					
Itching					
Popping sensation					
Feeling full/congested					
<b>SINUSES</b>					
Headache, facial pain					
Blowing out thick mucus					
Postnasal drip in back of throat					
Throat clearing					
Hoarseness of voice					
<b>BREATHING</b>					
<b>At awakening or during the day, do you have:</b>					
Wheeze					
Cough					
Sputum Production (coughing up material)					
Shortness of Breath					
Chest tightness					
<b>At night, do you wake up with:</b>					
Wheeze					
Cough					
Sputum production					
Shortness of Breath					
Chest tightness					

## **Consent for Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by Allergy Diagnostic Systems, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Allergy Diagnostic Systems, Inc. I understand that diagnosis or treatment of me by Dr. Barry Lampl or his staff may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Allergy Diagnostic Systems, Inc. is not required to agree to the restrictions that I may request. However, if Allergy Diagnostic Systems, Inc. agrees to a restriction that I request, the restriction is binding on Dr. Barry Lampl and his staff

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Barry Lampl or his staff has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Allergy Diagnostic Systems, Inc. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and has disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Allergy Diagnostic Systems Inc. The Notice of Privacy Practices also describes my rights and Allergy Diagnostic System's duties with respect to my protected health information.

Allergy Diagnostic Systems, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date