Primary Physician _____

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Adult Registration Form

☐ New Patient ☐ Edit Information

*****For All Patients over 18 years of Age *****

Please complete this form to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Please provide Photo ID

Patient Last Name: _____

First Name: _____ MI: _____

Preferred Name: _____

Date of Birth: _____

Gender:
☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F
☐ Decline to specify

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
☐ Life Partner ☐ Significant Other
☐ Other _____

Student Status:
☐ Full-time ☐ Part-time ☐ N/A

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Declined to specify

Race:
☐ American Indian/Alaska Native ☐ Asian
☐ African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Declined to specify

Preferred Language:
☐ English ☐ Spanish
☐ Other _____

Translator?
☐ YES ☐ NO

Comments: _____

Patient's Primary Address

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Patient's Reminders/Communication

This section is relative to preferred method of communication and Patient Portal access

Due to HIPAA regulations all patients over 18 must use their own information unless a legal guardian/court document is supplied.

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

☐ Web Enabled E-Mail: _____
☐ No Email ☐ Patient Refused

☐ Voice Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work
☐ Text Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

Types of reminders you wish to receive:
☐ Appointments ☐ Lab results ☐ Health Maintenance ☐ RX Confirmation ☐ General ☐ **ALL** ☐ **NONE**

Patient's Employment Information

Emp. Status:
☐ Employed FT ☐ Employed PT ☐ Not Employed ☐ Self ☐ Active Military ☐ Retired ☐ Reserved for Nat'l assignment

Employer: _____ Occupation: _____

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #: _____

_____

Patient's Emergency Contact

Last Name, First Name: _____ Patient's Relationship to Contact: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Insurance Information

Please provide a copy of ALL Insurance cards

Please let us know if this is a ☐ Worker's Comp Issue ☐ MVA ☐ Legal Case ☐ School Insurance

☐ Self-Pay (no insurance)

☐ Medicaid – ID Number: _____

Patient relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other _____

PRIMARY INSURANCE NAME:

Benefit Plan Name _____

Member ID: _____

Group#: _____ Effective Date: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Gender:

☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F

☐ Decline to specify

PCP listed on Card: _____

SECONDARY INSURANCE NAME:

Benefit Plan Name _____

Member ID: _____

Group#: _____ Effective Date: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Gender:

☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F

☐ Decline to specify

PCP listed on Card: _____

I have completed this form to the best of my knowledge and I understand I am to contact the office with changes to my personal information. I understand that I am responsible for all outstanding patient liabilities and financial obligations.

Patient Name: _____ *Date:* _____

Patient Signature: _____

If Patient has a Legal Guardian, a copy of the legal document granting you such power must be attached or on file with Advocare LLC.

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Annual Consent and Acknowledgment Form

This form is to be completed annually for Advocare LLC and scanned into each Patient's File

Patient Name: _____ DOB: _____

Address: _____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

Advocare and its parent, affiliates, associates, agents, services, debt collectors, independent contractors, assigns, successors, subsidiaries and employees (defined here collectively as "ADVOCARE" and referred to as "ADVOCARE" or "we") provide healthcare services (referred to collectively as the "Services"). By using the Services or accessing your account, any recipient of the Services accepts and also agrees to be legally bound by the terms of this Agreement to the extent permitted by law.

General Consent for Examination and Treatment

I hereby consent and authorize Advocare and all its physicians and ancillary medical personnel to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which my specific informed consent is not otherwise required. This consent includes consent and authorization to photograph or otherwise take images of me for purposes of identification, diagnosis, treatment, payment and healthcare operations. Any photographs or other images taken will become part of my medical record. Advocare will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advocare will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been offered a copy of Advocare's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Advocare has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, Advocare will post a new notice in its offices. I may contact Advocare at any time to obtain a current copy of the Notice of Privacy Practices. I may also access a copy on the Advocare website at www.advocaredoctors.com

Assignment of Benefits/Authorization/Notice of Collection

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles and charges denied by my insurance company as not covered or not medically necessary. You agree to reimburse Advocare the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt added to the debt at the time it is placed with the agency for collection, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Consent to Contact

You expressly authorize, and specifically consent to allowing, ADVOCARE and/or its outside collection agencies, outside counsel, or any other agents acting by or on behalf of ADVOCARE to contact you or any recipient of the Services with informational messages regarding your account, including but not limited to contact in connection with any and all matters relating to unpaid past due charges billed to you. You agree that such contact may be made to any mailing address, telephone number, cellular phone number, e-mail address, or any other electronic address that you or a recipient of the Services have provided, or may in the future provide, to ADVOCARE and to any and all telephone numbers billed on your account or any number where you or a recipient of the Services can be reached by ADVOCARE. You expressly consent and agree that such contact may be made using, among other methods, pre-recorded, artificial voice, or other message delivered by any type of telephone equipment including a dialer, automatic telephone dialing system, predictive dialer, interactive voice recognition system, or text message delivered by an automated system, pre-set e-mail messages delivered by an automatic e-mailing system, or any other pre-set electronic messages delivered by any other automatic electronic messaging system, including numbers assigned to any paging, cellular or mobile service, even for any service for which you are charged for the call or contact. Carrier message and data rates may apply. You agree to provide true, accurate, current and complete contact information about yourself and any recipient of the Services to ADVOCARE and its authorized agents and to promptly update this contact information to keep it true, accurate and complete. If you do not want ADVOCARE to use these telephone contact methods to reach you or a recipient of the Services, please contact us at 856.221.2700 to discuss how we may communicate about this account

Vaccine Registry (if applicable)

Our office submits confidential data of children and adult vaccinations to your state's Immunization Registry as permitted by state law. The purpose of this registry is to keep a central record of patients' immunization history.

Disclosures to Authorized Individuals

I designate the following person(s) listed below as a person(s) involved with my medical treatment and/or payment for my medical treatment. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. A copy of the authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical Treatment Information: Yes No Payment Information: Yes No

Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical Treatment Information: Yes No Payment Information: Yes No

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ N

Consent and Authorization

A copy of this consent and acknowledgment may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my PHI and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: _____ Date: _____

Patient Signature: _____

Legal Representative (if other than patient) Print Name: _____ Date: _____

Legal Representative Signature: _____ Relationship to Patient: _____

advocare Allergy & Asthma Your Health. Our Purpose.

Eugene. Gatti, MD* • Gregory Toci, DO* • Amandeep Sandhu, MD
Rebecca Kelly, APN

*Diplomates of the American Board of Allergy and Immunology
(A conjoint Board of the American Board of Pediatrics and the American Board of Internal Medicine)

*Fellows, American Academy of Allergy, Asthma and Immunology
*Fellows, American College of Allergy, Asthma and Immunology

Preparing for Your Visit

To ensure the safety of ALL our patients, we maintain fragrance-free offices. Please remember that all patients and those persons accompanying them to an office visit should refrain from wearing perfume, cologne, scented lotions, or any other cosmetic that may aggravate allergic or asthmatic conditions in any of our patients. We appreciate your cooperation in this very important matter.

It is your responsibility to have all the correct and current information prior to the office visit so that the provider can perform at accurate assessment. Our office cannot be responsible for calling to obtain this information the day of the visit. Failure to have the information may require you to come back for another visit prior to any formal assessment.

Please bring these items to your consultation:

- Picture identification (Parent's/Guardian if the patient is a minor).
- Proof of guardianship (if not legal parent).
- Valid insurance card(s).
- Current referral: it is your responsibility to obtain and verify that your referral was entered into the system by your primary care provider or other referring physician's office.
- Co-pay: we accept cash, check, or credit card.
- Name and address of primary care doctor and/or referring physician; name and address of local pharmacy and mail away pharmacy.
- Documentation of previous allergy or asthma evaluations: skin tests, blood tests, imaging studies, breathing tests. We do not have access to outside medical facilities, laboratories, or other physician's offices unless they are another Advocare physician's office.
- Current medications and dosages including herbal medication and vitamins.
- Previous X-rays, CAT scans, and/or blood work.
- Data about medication allergies or intolerances.
- Data about food allergies or intolerances.

All minors (patients under 18 years of age) must be accompanied by their parent or legal guardian. This adult should be familiar with their medical history. If a parent or legal guardian is not present at the visit, the patient must bring a signed letter from the parent/guardian authorizing us to see and treat the patient without them in attendance. The parent or legal guardian should be available by phone to speak with the office staff or medical provider.

If you require allergy skin testing, stop taking (or giving children) these medications at least three days prior to consultation:

- Alavert /AlavertD
- Allegra /AllegraD / Fexofenadine
- Astelin / Astepro / Azelastine
- Axid / Nizatidine
- Benadryl / Diphenhydramine
- Brompheniramine / Dimetapp / Dimetane / Nasahist
- Chlorpheniramine / Chlor-Trimeton / Histex
- Claritin / ClaritinD / Loratadine
- Clarinex / ClarinexD / Desloratadine
- Clemastine / Allerhist / Tavist
- Duradyl / Extendryl
- Pepcid / Famotidine
- Patanase / Olapatidine
- Tylenol PM
- Zantac / Ranitidine
- Zyrtec / ZyrtecD / Cetirizine
- Xyzal / Levocetirizine

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We have a waiting list for patients that need to be scheduled. Please be courteous and call us in advance to cancel your appointment so we may contact a patient waiting to be seen.

Patients must call to cancel their appointment **at least 48 hours in advance** or you will be charged **a $50.00 no-show fee**.

Paperwork must be completed and handed in at the time of the appointment. If the new patient information is not completed, you may be asked to reschedule. You should arrive 30 minutes prior to your appointment if you need to complete the paperwork. Please have copies of your medication list, lab work, imaging or prior allergy testing available for review at the time of the appointment. We will not call to obtain the information at the time of the appointment.

Your co-pay **must** be paid at the time of visit. You **may not be seen** if your co-payment is not paid.

If your insurance requires a referral, it must be presented at time of check-in. Otherwise, you **may not be seen**.

Your insurance card must be presented at every visit.

There may be a $20.00 fee for forms requiring the Provider's signature depending upon the complexity. Please allow seven (7) business days for completion of forms.

YOUR COOPERATION IS GREATLY APPRECIATED!

advocare Allergy & Asthma

ADULT

Patient Questionnaire/History

Date:_____ Date of visit: _____

Legal patient name_____ Preferred name if different _____

Date of birth_____Age_____ Gender M F NB Referring physician/Primary Doctor_____

Person providing information_____Relationship to patient _____

What is the reason for your visit? _____

PLEASE USE THE ATTACHED BLANK SHEET (PAGE 2) TO DOCUMENT ANY INFORMATION OR EXPLANATION.

Any season of the year worse for your symptoms? (circle) All year Spring Summer Fall Winter

Any triggers make your symptoms worse? (please check all that apply)

- ☐ Colds
- ☐ Smoke
- ☐ Perfumes
- ☐ Pets
- ☐ Dust
- ☐ Change in weather
- ☐ Change in temperature
- ☐ Cut Grass
- ☐ Mold
- ☐ Heat
- ☐ Pressure
- ☐ Strong Odors
- ☐ Sweating
- ☐ Activity
- ☐ Workplace/Home/School
- ☐ Other _____

FOR PROVIDER USE ONLY. DO NOT WRITE IN THE SPACE BELOW. LEAVE BLANK.

Eugene Gatti, MD • Gregory Toci, DO • Amandeep Sandhu, MD • Rebecca Kelly, APN

54 East Main St
Marlton, NJ 08053
856.988.0570

409 Kings Highway South
Cherry Hill, NJ 08034
856.988.0570
advocareallergyasthma.com

239 Hurfville-Crosskeys Rd, Suite 215
Sewell, NJ 08080
856.988.0570

FOR PATIENT USE:

PLEASE PROVIDE ANY INFORMATION/EXPLANATION YOU WISH TO RELATE TO THE PROVIDER ON THIS SHEET.

Medications

Include all prescriptions, over the counter medications, herbal meds, vitamins, and as needed medications,
Use an additional sheet or bring in a separate list if needed.

Name of Medication Dosage (ex: 20mg) Method (if not oral) Frequency (ex: 1 pill twice a day)

Previous allergy evaluation, blood work, skin tests, allergy shots, breathing tests, x-rays, CT scans and other doctors seen in the past (bring copies with you) ☐ No Previous Evaluations

Allergy History

Do you have any medication, food, bee sting, latex or x-ray dye allergies or reactions? (specify agent and reaction)

Medication Issues ☐ None

Food Issues ☐ None

Stinging Insect Issues ☐ None

Latex/Adhesive Sensitivities ☐ None

Xray Dye/RCM Issues ☐ None

Past Medical History

Do you have (or have you had) any of the following conditions? (circle)

Abnormal birth	YES	NO	Immune problems	YES	NO	Emphysema or COPD	YES	NO
Unusual childhood illnesses	YES	NO	Unusual infections	YES	NO	Diabetes	YES	NO
Asthma	YES	NO	Anxiety/panic attacks	YES	NO	Thyroid problems	YES	NO
Nasal or eye allergies	YES	NO	Depression	YES	NO	Anemia	YES	NO
Eczema	YES	NO	ADD / ADHD	YES	NO	Liver problems	YES	NO
Hives	YES	NO	Arthritis	YES	NO	Prostate problems	YES	NO
Swelling of body parts	YES	NO	Osteoporosis	YES	NO	Heartburn or reflux	YES	NO
Chronic sinus problems	YES	NO	Seizures	YES	NO	Palpitations	YES	NO
High blood pressure	YES	NO	Migraines	YES	NO	Kidney problems	YES	NO
High cholesterol	YES	NO	Cancer	YES	NO	Stroke	YES	NO

Explain any YES answers. List any other medical issues, major illnesses, or other reasons you may see a doctor

_____

_____

_____

Please list all previous surgeries, hospitalizations and emergency room visits **(include dates, body side R / L and reason)**

Surgery history☐ None_____

_____

_____

_____

Hospitalizations☐ None _____

_____

_____

_____

ER Visits☐ None _____

_____

_____

_____

Personal and Social History of Adult Patient

Marital Status Never Married Married Widowed Divorced Separated Other

Number of children_____ Ages _____

Occupation_____ Employer _____

Have you missed any work or school this year due to illness? YES NO N/A If so how many days _____

Do you have any of the following? (circle) No Barriers

glasses / contacts poor hearing language barrier religious/cultural barrier

Have you received all routine immunizations (for your age)?	YES	NO
Have you received a flu shot this year?	YES	NO
Have you received an adult pneumonia shot in the past?	YES	NO

If so, when: _____

Any chemical or allergic exposures at work or school? YES NO N/A If so, describe: _____

Any hobbies, travel or previous work exposures? YES NO N/A If so, describe: _____

Have you ever used tobacco products? YES NO N/A QUIT If you quit, when: _____

Cigarettes _____ Cigars _____ Chewing Tobacco _____ Vaping _____

If yes (or quit), how many packs a day? _____ Approximate years smoking _____

Do you consume alcoholic beverages? YES NO N/A

If so how many average alcoholic drinks per week_____

Have you ever used recreational drugs? YES NO N/A

If so, are you still currently using? YES NO N/A If so, type_____

Do you exercise regularly or play sports? YES NO N/A

If yes, what do you do _____

Family Medical History ☐ **Adopted** ☐ **Unknown**

Has any family member been diagnosed with any of the following? (please check)

	Mom	Dad	Children	Siblings	Other-explain
Age/Year of Birth, Alive (A) or Deceased (D)					
Unusual Childhood illnesses (if yes, type)					
Asthma					
Nasal or Eye Allergies					
Eczema					
Hives					
Swelling of body parts					
Diabetes					
High blood pressure					
High cholesterol					
Celiac Disease					
Food Intolerances/Sensitivities (Type)					
Emphysema or COPD					
Thyroid problems					
Migraines					
Immune problems (if yes, type)					
Unusual infections (if yes, type)					
Cancer (if yes, type)					
Heart disease before 55 years old					
Heart disease after 55 years old					
Other medical conditions (if yes, type)					

Explain any yes answers:

_____

_____

_____

_____

Environmental History for Primary Residency (If multiple, answer separately)

Who do you live with?					
Does anyone you live with smoke?	YES	NO	Who smokes?		
Any pets in the home?	YES	NO	List types & number of pets		
If yes, do the pets go in the bedroom?	YES	NO			
Do you sleep with the pets?	YES	NO			
What type of housing is it?	House	Apt	Condo	Other	
How old is your housing?					
Do you have a basement?	YES	NO			
If yes, is the basement used?	YES	NO			
The basement is	DRY	DAMP			
Has the basement ever flooded or gotten wet?	YES	NO			
What kind of heat do you have?	Gas	Oil	Propane	Other	
	Vents	Radiators	Baseboard	Other	
Do you have a fireplace?	YES	NO	Gas	Wood-burning	
If yes, is it used?	YES	NO			
Do you have air conditioning?	YES	NO	Central	Window Units	
If yes, is it used?	YES	NO			
Do you have any special air filters?	YES	NO			
If yes, where are they?					
Do you have any dehumidifiers?	YES	NO			
If yes, where are they?					
What kind of flooring do you have on most of the floors?	Hardwood	Area Rugs	w/w Carpet	Other	
What kind of flooring do you have in the bedroom?	Hardwood	Area Rugs	w/w Carpet	Other	
What kind of covering do you have on the windows?	Blinds	Shades	Curtains	Other	
Do you have any stuffed toys or collectibles?	YES	NO			
If yes, how many?	A few	Many	Too Many		
How old is your mattress?					
Any special allergy covers?	YES	NO	On the Mattress	On Pillows	
Any feather, down, or goose bedding?	YES	NO			
What kind of vacuum do you have?	Regular	HEPA	Central	Other	None
Any other living conditions (dorm room, split custody, other homes)?	YES	NO	Describe		

Name & location of local pharmacy _____

_____

Mail-away pharmacy _____

Review of Systems

Have you had any significant or recurrent problems with the following? (please check all that apply)

Constitutional	□ Weight loss	□ Weight gain	□ Fatigue	□ Temperature intolerance
	□ Fever	□ Chills	□ Loss of appetite	
Facial	□ Tenderness	□ Swelling	□ Pain	
Eyes	□ Visual Problems	□ Glasses	□ Contacts	□ Eye Pain
	□ Itchiness	□ Redness	□ Swelling	□ Dark Circles
Nasal	□ Itch	□ Sneezing	□ Congestion	□ Change in Sense of Smell
	□ Bleeding	□ Discharge	□ Sinus Infections	
Ears	□ Blockage	□ Itch	□ Pain	□ Ringing
	□ Hearing Loss	□ Infections	□ Ear Tubes	□ Ruptured Ear Drums
Oral/Throat	□ Dental Issues	□ Bad Breath	□ Change in Voice	□ Change in Sense of Taste
	□ Sore Throat	□ Thrush	□ Hoarseness	□ Snoring
	□ Post-nasal Drip		□ Frequent Strep	
Respiratory	□ Shortness of Breath	□ Cough	□ Cough with Activity or Laughter	□ Wheezing
	□ Chest Tightness	□ Cough up Blood	□ Nighttime Cough or Awakening	□ Frequent Pneumonia
	□ Frequent Bronchitis	□ Cough up Mucus	□ Colds that always go into the chest	
Cardiovascular	□ Chest Pain	□ Palpitations	□ Irregular Heartbeat	□ Exercise Intolerance
	□ Feeling Faint	□ Murmurs		
Gastrointestinal	□ Stomach Pain	□ Constipation	□ Diarrhea	□ Nausea
	□ Vomiting	□ Hepatitis		
Skin	□ Rashes	□ Sensitive Skin	□ Easy Bruising	□ Blueness of Hands or Feet
Musculoskeletal	□ Joint Pain/Swelling	□ Muscle Pain/Cramps/Weakness		□ Arthritis
Neurologic	□ Sinus Headaches	□ Migraine Headaches	□ Generalized Headaches	□ Dizziness
	□ Numbness	□ Difficulty with Balance	□ Sleep Apnea	□ Memory Problems
	□ Insomnia	□ Problems with speech		□ Vertigo
Psychiatric	□ Depression	□ Anxiety	□ Mood Disturbances	□ Psychiatric Illness
Endocrine	□ Thyroid Problems	□ Hormonal Issues		
Hematological	□ Anemia	□ Bleeding	□ Previous Blood Transfusions	
	□ Swollen Lymph Nodes	□ Jaundice	□ Low Blood Counts	

Use this space to explain any positive answers if necessary

_____

_____

_____

_____

_____

_____

Patient Signature_____ Date _____

Physician Signature_____ Date _____