NORTH SHORE ALLERGY AND ASTHMA, S.C.
PROBLEM LIST AND CURRENT MEDICATION LOG

Today's Date:

PATIENT NAME:		DOB:
PRIMARY CARE PHYSICIAN:		PHONE:
PRIMARY PHARMACY NAME:	LOCATION:	PHONE:

ANY DRUG ALLERGIES? IF YES, PLEASE LIST:

ARE YOU A SMOKER? YES OR NO IF YES, HOW MANY PACKS PER DAY?
HAVE YOU HAD AN INFLUENZA VACCINE RECENTLY? YES OR NO IF SO, WHEN?
PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING STRENGTH AND TIME OF DAY USED
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

NORTH SHORE ALLERGY AND ASTHMA, SC.

___Dr. Daddono ___ Dr. Gupta ___Dr. Shah

Patient Registration

FOR OFFICE USE ONLY

ACCOUNT #_________ PREPARED BY ________ DATE _________ OFFICE________ENTERED INTO SYSTEM BY ________ DATE _________

Patient Information

Last Name ____________________ First Name ________________________ M.I. ___ Date of Birth __________

Address ______________________________ Apt. _____ City ________________ St. ____ Zip ___________

Home # _____________________ Work #_____________________ Cell Phone # ____________________

Marital Status ___S ___M ___D ___W Gender ___M ___F Language _____ Race ______

Names of immediate family members that see our physicians?

1. ____ 2. ____

Emergency Contact _______________________ Phone # _____________ Relationship _________________

Bills Sent To: (must be filled out)

Relationship to Patient ____

Last Name ___________________________________ First Name ___________________________ M.I. ___

Address _________________________ Apt. _____ City ____________________ St. ____ Zip __________

Home # _______________________ Work #_____________________ Cell Phone #_________________

Medical Information

Pertaining to your condition, have you had any of the following? ___Cat-Scan ___X-ray ___MRI ___Bloodwork

Where ____________________________________ When ____________________________________

Referring Physician _______________________ Primary Care Physician ___________________________

Is this visit related to a work injury? ___Y ___N If yes, please stop and notify the front office staff.

Pharmacy Used? ______________________ Pharmacy Location? _________________________________

Primary Medical Insurance (Including Medicare & Medicaid)

Check One ___ PPO ___POS ___HMO ___OTHER EFFECTIVE DATE ____________________

Insurance Company _________________________ Insurance Co. Phone # ____________________________

Claim Mailing Address ____

Ins I.D. # ________________________________ Group # _________________

Primary Card Holder _______________________ Date of Birth ______ __ Self __Spouse __Parent/Guardian

Employer of Insured ______________________________ Insured's Work Phone # _____________________

Secondary Medical Insurance

Check One ___ PPO ___POS ___HMO ___OTHER EFFECTIVE DATE ___________________

Insurance Company ________________________________ Insurance Co. Phone # ___________________________

Claim Mailing Address ____

Ins I.D. # ___________________________________ Group # ___________________ S.S. # ___________________

Primary Card Holder _________________________ Date of Birth _______ __ Self __Spouse __ Parent/Guardian

Employer of Insured _____________________________________ Insured's Work Phone # ______________________

Tricare Insurance Only

___ Primary ___ Secondary ___ Other Check One ___Standard ___Prime

Patient's Relationship to Policy Holder ________________ Is the policy holder ___retired or ___active?

What is the policy holder's rank? ______________________ Policy Holder's SS# __________________________

Policy Holder's Name____ Policy Holder's Date of Birth____________

Insurance

In order to file claim on the behalf of the patient, we must have a copy of the insurance card and the complete address of where the claim is to be sent. Without this information, you will be billed directly.

We accept Medicare, most major insurance, numerous PPO and managed care contracts. Be aware that your insurance provider may consider some, and perhaps all, of the services provided not medically necessary. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. As a service to you we will submit all claims for charges to your insurance. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please call our business office at (847) 662-2454.

Having more than one insurance company does not necessarily mean that our services are covered 100%. We may bill your secondary carrier as a courtesy; however, you will be responsible for following up on unpaid claims and any balances after your insurances have cleared.

Financial Policy

Thank you for choosing our physicians as your allergy and asthma specialists. We are committed to your treatment being successful. Please understand that timely payment of your bill is considered part of your treatment and your clear understanding of our Financial Policy is important to our professional relationship. If you have any questions about fees or our Financial Policy please contact our billing department at (847) 662-2454.

Our Financial Policy is as stated:

- All patients must complete our "PATIENT REGISTRATION FORM"
- All co-pays, co-insurance, and deductibles are due at the time of service.
- Payment of patient balance is due in full at the time of service unless other arrangements have been made. If you cannot make full payments at the time of service please call our business office to make payment arrangements at (847) 662-2454.
- We accept cash, check, Visa, and MasterCard **ONLY**. If paying by check, we will charge a $20.00 fee for all returned checks.
- If any portion of your balance exceeds sixty (60) days, you will be responsible for this amount plus interest hereon at 1.5% per month regardless of your insurance.

Minor Care Authorization

MUST BE COMPLETED FOR ALL MINOR PATIENTS

I hereby grant to Dr's Daddono, Gupta

, and Shah to perform any emergency treatment necessary for

_________________________ _________________________

Minor's Name Parent/Guardian's Signature

Signature X____________________________________ Date_____________________

NORTH SHORE
ALLERGY AND ASTHMA, S.C.

Anthony Daddono, M.D.
Parthiv Shah, M.D.
Alekh Gupta, M.D

EXTERNAL RX HISTORY CONSENT FORM

This form entitles North Shore Allergy and Asthma, S.C. to access my external prescription history from participating electronic prescription service, as well as transfer your prescriptions electronically to the pharmacy of your choice.

* External prescriptions may include those prescribed by another provider.

Opt in Signature____

Opt out Signature____

North Shore Allergy & Asthma, S.C.

1790 Nations Dr #102	1900 Hollister Dr #320	1475 Belvidere Rd #212
Gurnee, IL 60031	Libertyville, IL 60048	Grayslake, IL 60030

Anthony Daddono, M.D. **Alekh Gupta, M.D.** **Parthiv Shah, M.D.**

I hereby authorize my insurance benefits to be paid directly to the above assigned physicians for todays and all future services. Realizing I am responsible to pay any non-covered services. I hereby authorize the release of pertinent medical information to my insurance carrier(s).

______________________________ ________________

Patient Signature/ Guarantor Date

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I acknowledge that I have received NSAA's *Notice of Privacy Practices* containing the description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at anytime at an address above to obtain a current copy.

____

Patient Named (Printed)

____

Relationship to Patient

______________________________ ________________

Signature Date

NORTH SHORE ALLERGY & ASTHMA M.D., S.C.

1790 NATIONS DR. #102
GURNEE, IL 60031

1900 HOLLISTER DR. #320
LIBERTYVILLE, IL 60048

1475 E. BELVIDERE RD. #212
GRAYSLAKE, IL 60030

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out your treatment, payment or health care operations (TPO) and for other purposes that are permitted required by law. It also describes your right to access and control your protected information that may identify you and that relates to your past, present, and/or future physical/mental health/condition and related health care services.

This notice was published and becomes effective on/or before April 14, 2000.

Uses and Disclosures of Health Information

We use and disclose information about you for treatment, payment, and healthcare operations.

Treatments: We may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent. Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician, or the physician's practice, has taken an action in reliance in the use or disclosure indicated in the authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.