Carmine J. De Fusco, M.D., P.A.

Allergy, Asthma and Clinical Immunology

224 Taylors Mills Road Suite 106 Manalapan, N.J. 07726-3281

Phone {732} 462-0666 Fax {732} 462-0992

Welcome to our office!

In this packet you will find: a Patient HIPAA, Financial Policy Form & Patient Consent and an Assessment Form.

The assessment form is 6 pages along, please fill it out completely.

If any section does not apply to your child, then please mark it with “N/A.”

Please bring all the completed forms; your insurance card, photo id, co-pay and your referral (if required).

If you have any questions please call 732-462-0666.

We look forward to seeing you.

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PEDIATRIC ASSESSMENT FORM

Date_____

Child's Name _____

Mother's Name_____ Occupation_____

Father's Name_____ Occupation_____

Address _____

Home #_____ Mom's Cell_____ Dad's Cell_____

Contact Preference: Home Mom's Cell Dad's Cell

E-mail Address _____

Sex: M F DOB _____ Height _____ Weight _____

Race: White Asian African American Indian Other

Ethnicity: Not Hispanic Hispanic/Latino Mexican Puerto Rican Other

Pediatrician _____

Pharmacy Name & Address_____

Preferred Lab LabCorp Quest CentraState JerseyShore Other

Primary Insurance Carrier _____

Policy Holder's Name _____

Policyholder: Mom Dad Step-Mom Step-Dad other

Policy Holder's DOB _____ Effective Date _____ Specialist Copay _____

Group # _____ ID# _____

Secondary Insurance Carrier _____

Policy Holder's Name _____

Patient's Relationship to Policyholder: Mom Dad Step-Mom Step-Dad other

Policy Holder's DOB _____ Effective Date _____ Specialist Copay _____

Group # _____ ID# _____

Chief Complaint(s)_____

Has your child ever had these symptoms before? yes no If so, when? _____

When did his/her symptoms begin? _____

How often do they occur? _____

Does your child miss school due to his/her symptoms? yes no

What do you think causes these symptoms? _____

Circle the season(s) when it is most severe: Winter Spring Summer Fall

What part(s) of the body are affected? _____

What do you think makes it worse? _____

What do you think makes it better? _____

List any activities engaged in prior to the onset of symptoms: _____

_____

List any different/unusual foods or drinks consumed prior to the onset of symptoms: _____

_____

List any new/different environmental factors at home or school: _____

_____

What ALLERGY medication(s) is your child taking? _____

What NON-ALLERGY medications is your child taking? _____

What medications has your child tried previously?_____

_____

What medications/treatments help the most? _____

_____

ADVERSE DRUG REACTIONS

Date	Drug	Reaction	Has it been used since

ADVERSE FOOD REACTIONS

Date	Food	Reaction	Can it be eaten now?

Circle all the foods your child has had a reaction to: dairy eggs soy grains fish meat chocolate shellfish fish vegetables nuts colorings/dyes preservatives none other _____

PREVIOUS MEDICAL HISTORY

Date	Diagnosis	Confirmed by History	Confirmed by Physical Exam	Confirmed by Skin Test	Confirmed by Lab Test

Previous surgeries and date performed: _____

_____

LIVING ENVIRONMENT - PLEASE CIRCLE YOUR RESPONSES

Where do you live? house condo townhouse apartment other_____

Age of home? 1-5 years old 6-10 years old 11-20 years old more than 20 years old unknown

Where is your home located? city suburbs country farm shore

Is your basement? no basement damp dry

Is your basement? cluttered/dusty clean fully finished partially finished unfinished

What type of heating system do you have? forced hot air baseboard radiator thermal

What type is it? gas oil liquid propane electric

What type of filter? basic furnace dense fiber filter permanant electrostatic disposable elecrostatic Hepa-type washable filter none

Do you have a humidifier? yes no

What type of air-conditioning do you have? central window wall mount none

Do you have a dehumidifier? yes no

Do you have potted plants in the home? yes no

Bedding- mattress & box spring mattress only air mattress memory foam crib mattress

Age of mattress- 1-3 years old 3-5 years old 5-10 years old more than 10 years old

Do you use mattress covers? yes no

What type of Blankets- wool cotton quilt down comforter hypoallergenic synthetic quilt

Pillows- synthetic down/feather cotton memory foam hypoallergenic no pillows

Are the pillows encased in a hypoallergenic covering? yes no

Bedroom Flooring- wall-to-wall carpeting hardwood floors vinyl flooring area rugs

Window coverings- drapes curtains blinds fabric shades

How often are they cleaned? more than 3 times a year at least once a year not regularly

Is your child exposed to second-hand smoke in the home? yes no

If yes, how many smokers in household? 1 smoker 2 smokers 3 or more smokers

Do you have pets? yes no If yes, what kind & how many? _____

SOCIAL HISTORY-PLEASE CIRCLE YOUR RESPONSE

Does your child attend: daycare preschool grade school

If yes, how often? _____ What grade is your child in? _____

Are your child's symptoms worse at school? yes no

If yes, what type of symptoms? nasal respiratory skin

Does your child consume caffeine? yes no

If yes, how much? 1 or 2 times per week 1-2 per day 3-5 per day 6 or more per day

Please list your child's hobbies & interests: _____

_____

PLEASE MARK ANY FAMILY MEMBERS THAT HAVE/HAD ANY OF THE FOLLOWING CONDITIONS

ILLNESS	FATHER	MOTHER	BROTHERS	SISTERS	Age When Diagnosed	
Hay Fever						
Asthma						
Eczema						
Hives						
Food Allergies						
Drug Allergies						
Emphysema						
Thyroid Disease						
Sinusitis						
Insect Sting Allergy						
Migraines						

Nose:

Does your child have AM nasal congestion? yes no

If yes, does it? slowly improve persist throughout the day

Does your child snore? yes no If yes, how often? occasionally frequently

How often does your child sneeze? never occasional frequently

Is your child's nose itchy? never spring summer fall winter

Does your child clear his/her throat? yes no If yes, how often? occasionally frequently

Secretions: clear cloudy varies

Does your child have post-nasal drip? yes no If yes, how often? occasionally frequently

Secretions: clear cloudy varies

When is it worse? spring summer fall winter perennially

Where is it worse? home school indoors outdoors

Mouth:

Does your child breathe through his/her mouth? yes no

If yes, how often? occasionally frequently constantly

Does the roof of his/her mouth itch? yes no

Sinuses:

Does he/she get sinus infections? never spring summer fall winter perennially

If yes, how many per year? 1-2 3-4 5-6 more than 6 times per year

If yes, do he/she usually need antibiotics? yes no

Does your child get sinus headaches? yes no If so, how often? never occasionally frequently

Where does his/her head hurt? face forehead side back entire head

Ears: How is your child's hearing? normal mild loss on right mild loss on left mild loss bilaterally

Does your child have ringing in his/her ears? never occasionally frequently constantly

Do his/her ears feel stuffy? never occasionally frequently constantly

If yes, where? right left bilaterally

Does your child have pain in his/her ears? yes no

If yes, how often? occasionally frequently constantly Where? right left bilaterally

Do your child's ears itch? yes no

If yes, how often? rarely occasionally frequently constantly

Eyes:

Do your child's eyes: itch get red watery swollen no

Lungs:

Does your child experience: coughing wheezing shortness of breath none

Has your child ever been sent to the Emergency Room or admitted to the hospital? yes no

Skin:

Does your child have any dermatologic problems? yes no If yes? eczema hives both

How often does your child have hives? never occasionally frequently

When is it worse? winter spring summer fall

What areas are affected? hands arms crease of the arm neck face chest abdomen back legs feet crease behind the knee

Triggers: dust pollen mold smoke cat dog cut grass musty places anxiety exercise foods heat pollution respiratory irritants infections

Gastrointestinal:

Does your child have gastroesophageal reflux (GERD)? yes no

If yes, what tests have been done? _____

How controlled is your child's condition? not controlled partially controlled completely controlled

What medications are controlling your child's condition? _____

Has your child had significant weight gain? yes no Experienced recent weight loss? yes no

If so, how much? _____

Has your child ever had a reaction to insect stings? yes no

If yes, what type of reaction? localized general

Does your child experience frequent fevers? yes no If yes, how high? _____

Does your child suffer from any cardiac problems? yes no

If yes, what type of problems? high blood pressure high cholesterol high triglycerides

Does your child suffer from urinary problems? yes no

If yes, what type of problems? frequency pain burning difficulty with urination

Does your child suffer from muscular/skeletal problems? yes no

If yes, what type of problems? pain swelling joint stiffness

Does your child suffer from any neurological problems? yes no

If yes, what type? _____

Does your child suffer from any blood disorders? yes no

If yes, what type? _____

Does your child suffer from diabetes? yes no

Does your child have any thyroid problems? yes no

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Authorization of Benefits

I hereby assign, and authorize payment, directly to Carmine J. DeFusco, M.D, P.A. the medical benefits to which I am entitled under my insurance policy(s). I understand that I am financially responsible to said doctor for charges not covered by this assignment: including, but not limited to my copay, co-insurance and/or deductible(s).

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Signature_____

Financial Policy

I understand that my copay MUST be paid upon check-in. Co-pays cannot be billed, this is an insurance company regulation.

If a referral is required, I understand that it is my responsibility to obtain this referral from my primary care physician. The referral must FAXED to {732} 462-0992, before my appointment. I further understand that if the referral is not provided, I will be responsible for all charges related to that visit.

I am responsible for any amount not paid by my insurance company. This amount may be, but not limited to: a copay, co-insurance, and/or deductible. This amount will be billed to me via a monthly statement, after my insurance has been processed & the insurance company has advised Dr. DeFusco's office the total amount of my responsibility.

A "Service Charge" of 2% per month MAY accrue on any balance left unpaid for more than 30 days from my statement date. Any amount left unpaid for more than 90 days will be considered delinquent, be referred to a collection agency, or an attorney, and reported to various credit reporting agencies. If my account is referred to a collection agency, or an attorney, I will be responsible for the payment of any additional fees.

Print Patient Name_____

Parent's Signature _____

Date _____

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Patient HIPAA Consent & Release of PHI

By signing this consent you are authorizing Dr. Carmine J. DeFusco, and the office staff, to use and disclose your personal health information (PHI) to perform routine office operations. Your PHI may be used to: bill and collect payment for services rendered, obtain drug prior authorizations, obtain laboratory results, etc.

You have the right to request that we restrict how your health information is used. We are not required to agree with your request. You may request a copy of our "Notice of Privacy Practices."

You have the right to revoke this consent except where we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing.

Print Patient Name _____

Parent Signature_____

Date_____

This consent may be revoked by the patient at any time but must be done so in writing.

Thank You!

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Patient Consent

Patient Chart Sharing

By initialing here _____ you give your consent to have the "Patient Chart Sharing" feature enabled in your EHR. When enabled, we will have the ability to automatically exchange your medical records with providers who care for you at connected care locations.

Medication History Authority {we strongly encourage this feature}

By initialing here _____ you grant Dr. DeFusco, and his staff, permission to download the your medication history automatically from pharmacy benefit managers; from "the cloud".

Consent to Call

By initialing here _____ you indicate that you have agreed to receive automated phone calls from Dr. DeFusco's practice on your mobile phone. Depending on the features our practice offers, phone calls may be about appointments, test results, and more. {mobile #_____}

Consent to Text

By initialing here_____ you indicate that you have agreed to receive automated text alerts from Dr. DeFusco's practice on your mobile phone. Depending on the features our practice offers, text alerts may be about appointments, test results, and more. {mobile #_____}

Family Billing {only applicable if more than one family member is a patient}

By initialing here _____you indicate that you wish to have this billing feature enabled on your account. A single "Guarantor" is named for the family account; who will then receive a single statement for the entire family, itemized by patient, with details for each transaction. Payments made on the "Family" account are applied to the oldest, open charges first. Enabling this feature greatly simplifies both monthly billing and payments. Family balances are available on check-in screens when you come in for appointments. Payments get applied to oldest balances first so as to keep your account as current as possible. If you have any additional questions, please see Lisa.

Family Guarantor_____
Family Member #1 _____
Family Member #2_____
Family Member #3_____
Family Member #4_____

Not initialing any individual section above, is considered non-consent and that feature will not be enabled on your EHR.

Patient Name _____
Parent Signature _____
Date Signed _____