RICHARD R. ROSENTHAL, M.D., LTD.

8318 Arlington Blvd., Suite #308
Fairfax, Virginia 22031
Telephone: (703) 573-4440

Fax: (703) 280-4650

1830 Town Center Drive, Suite #206
Reston, Virginia 20190
Telephone: (703) 437-5151

WELCOME

Dear New Patient,

Welcome to our practice. We appreciate the opportunity to provide your care and look forward to serving you. We have been serving the northern Virginia community for over 40 years in treating children and adults for hay fever, sinus trouble, chronic cough, asthma, food and drug allergies, stinging insect allergies, skin allergies, hives, eosinophilic esophagitis and much more. If you have not already done so please call 703-573-4440 to schedule an appointment and note the date and time below for easy reference:

Day_________________Date__________________Time__________

Provider Name__________________________________

Please check the office where you made your appointment:

____Fairfax Office: 8318 Arlington Blvd., Suite 308, Fairfax, VA 22031

____Reston Office: 1830 Town Center Drive, Suite 206, Reston, VA 20190

Please remember to bring the following items to your appointment:

- Insurance Card (current)
- Picture ID
- List of your current medications (including prescription, over-the-counter, and herbal)
- Any recent lab, x-ray or other reports/documents pertinent to your appointment
- **All** of the downloaded new patient forms **completely filled out** (unless you fill them out on the patient portal)

Please plan to arrive 15 minutes prior to your scheduled appointment to allow time to check-in at the front desk. This will help to keep appointments flowing smoothly.

Your appointment may need to be rescheduled if you:

- Go to the wrong location
- Do not bring the items listed above
- Do not bring a referral (if required by insurance)
- Arrive later than your appointment time
- Take antihistamines prior to a skin testing appointment

We do not want to have to reschedule you, so we urge you to keep this form handy and follow the instructions on the day of your appointment. If you need to **cancel or reschedule** your appointment, we ask that you please give us **24 business hours' notice**. There is a $50 charge for late cancellations and missed appointments.

If you have any questions or need to reschedule, please call us at 703-573-4440. We look forward to seeing you and providing for your care.

REGISTRATION FORM

RICHARD R. ROSENTHAL, M.D., LTD.

703-573-4440
www.allergysource.org

PLEASE PRINT

Name:________________________ _________________ ________________________ ___________ ___________
First Middle Last Suffix Preferred

Date of Birth: _________________ Age: _____

Address: ____ City:__________________ State:______ Zip:__________

Home Phone: ______________Work Phone: ______________Cell Phone: _____________E-mail address: _____________________

Contact By : ☐Phone ☐Letter ☐E-mail ☐Secure Message Sex: ☐ Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed SS#:______________________

Referring Physician Name*(Not Group)***:** _______________________Address:______________________________Phone: _____________

Primary Care Physician Name *(Not Group)***:**________________________Address: _________________________Phone: ____________

Demographic Information: Federal Government Regulations Require Us to Collect the Information Below:

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black or African American ☐More Than One Race
☐Native Hawaiian ☐Other Pacific Islander ☐Caucasian ☐Decline to Report ☐ Other

Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Report **Preferred Language**:______________

Guarantor (Responsible Party): Self _____ Parent ______ Other _______

Name of Guarantor (if other than self) ________________________ SS#: __________________ Date of Birth______________

Address of Guarantor:_______________________________________City:________________State:______Zip:_________

Your Employer: ___________________________ **Your Occupation:** _______________________________

Primary Medical Insurance: _________________________ If **required, did you bring a referral?** ________

Insured Party: Self ___ Spouse ___ Parent ___ Other ___ ID#: __________________Group/Plan #: ______________

If other than self, please provide the following information for the insured party:

Name: ______________________________ Date of Birth:_______________ SS#:__________________

Address:_______________________________________City:__________________State:______Zip:_______

Secondary Medical Insurance: _______________________ **If required, did you bring a referral?** _________

Insured Party: ☐Self ☐Spouse ☐Parent ☐Other ID#: __________________Group/Plan #: ______________

If other than self, please provide the following information for the insured party:

Name: ______________________________ Date of Birth:_______________ SS#:__________________

Address of Insured Party:____City:__________________State:______Zip:_______

Person to Contact in Emergency: _________________ Relationship: _________ Phone: _____________(C)(W)(H)

Preferred Pharmacy: _________________ Phone Number:_____________________ Fax Number:_______________

Address:____________________________________ _______City:___________________ State______ Zip__________

Preferred Lab (If you are unsure, please check with your insurance company regarding covered services prior to your appointment.):

☐Quest ☐Labcorp ☐No Preference

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I authorize the release of my office visit notes to my primary care or referring physician. I authorize the release of any information necessary to process insurance claims and the release of information if collection measures should become necessary. Additionally, I will be responsible for all collection and attorney fees. I also authorize payment of benefits to the physician or supplier of services rendered. I understand that certain charges may not be covered and that I am financially responsible for all charges incurred.

SIGNATURE: ____________________________________ **DATE:** ________________________

RICHARD R. ROSENTHAL, M.D., LTD.

Adult and Pediatric Allergic Disease, Asthma and Immunology

Office Policy

Thank you for choosing our office to provide your allergy care. We are committed to the success of your treatment. Timely payment of patient accounts is consistent with our commitment to timely treatment and 24/7 availability. The following is a statement of our office policy which we ask all patients to read and sign prior to treatment.

Regarding Insurance

A patient's health insurance is a contract between the patient and his/her insurance company. As such you are responsible for understanding your policy reimbursement requirements. If we participate with your health insurance company, and you have supplied insurance information, we will bill your insurance carrier for you. ***Patient co-payments and deductibles are due at the time of your visit.*** Please supply updated insurance information if your insurance changes. An administration fee of $5.00 will be charged to your account if it becomes necessary to re-submit claims to a new carrier or it becomes necessary to mail a statement to you for unpaid office visit co-payments. If your insurance carrier has not paid your claim in forty-five days the balance will automatically be billed to the patient.

Most Health Maintenance Organizations (HMO) require a patient to have a referral form their primary care physician prior to receiving specialist treatment. ***HMO patients are responsible for obtaining and monitoring their referrals.***

In the event we do not participate with your health insurance company, payment in full will be expected at the time of your visit. We accept cash, checks and Visa, Mastercard, and Discover cards as payment.

Usual and Customary Rates/Interest

Our fees are considered usual and customary for our specialty in the Washington, D.C. metropolitan area. We reserve the right to charge interest in the amount of 1.5% per month on the unpaid balance (18% annual) as provided by state law.

Adult Patients/Minor Patients

Adult patients are responsible for payment at time of service. The adult accompanying a minor and the parents (or guardian) are responsible for payment.

Missed Routine Appointments

Unless canceled twenty-four business hours in advance (one entire business day), our **policy is to charge for all missed appointments at the rate of a normal office visit.** Please help us serve you and all of our patients better by keeping scheduled appointments.

Medical Records Request

If you require a copy of your medical record in the future from our office, Virginia State law requires a signed request from you. In accordance with state and federal regulations we may charge for preparing a copy of your medical record. If you are bringing records to our office from another provider, ***please retain a copy of those records.*** Inactive patient records (patients not seen by the physician for an office visit) are maintained for a maximum of seven years. After seven years inactive medical records are destroyed.

Authorization

I have read the above office policy and agree to the terms listed. I authorize payment of benefits to the physician or supplier for services rendered. Certain charges may not be covered by my insurance and I understand that I am financially responsible for all charges incurred.

Thank you for taking the time to review our office policy. Please let us know if you have any questions or concerns.

____ Date _________________________

Signature of Patient or Responsible Party

Richard R. Rosenthal, M.D., LTD.
Consent Form for ePrescribe Program

Patient Name: ____ **Date:** ______________________

ePrescribe Program

ePrescribing is a way for doctors to electronically send an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program greatly reduces medication errors and enhances patient safety. The ePrescribe program also includes:

- **Formulary and Benefit Transactions** – Gives the health care provider information about which medications are covered by your drug benefit plan.

- **Medication History Transactions** – Provides the health care provider with information about medications the patient is already taking to minimize the possibility of adverse drug events such as drug-drug and drug-allergy interactions and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Richard R. Rosenthal, M.D., Ltd. as well as other health care providers involved in your health care.

Consent

By signing this consent form you are agreeing that your provider at Richard R. Rosenthal, M.D., Ltd. may request and use your prescription medication history from other health care providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Richard R. Rosenthal, M.D., Ltd. to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____________________________Print Patient Name ___________Patient DOB

_____________________________Signature of Patient or Guardian ___________Today's Date

_____________________________Relationship to Patient

Richard R. Rosenthal, M.D., LTD.
Patient Questionnaire

Patient Name: ______________________________ **Date:** ______________________

Person filling out form: ______________________________ **Relationship to patient:** ____________

How did you hear about our office? ____

History of Present Illness:

Primary Problem(s): Why are you coming to see us? What are your symptoms?

____

____

____

Please circle which month(s) your symptoms occur:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Which month(s) are worst? ____

What makes your symptoms worse? Mornings Nights At Home At Work

Grass Damp Places House Dust Animals Foods Aspirin

Tobacco Smoke Road Dust Perfumes Strong Odors Cold Air

Rapid Temperature Changes Alcohol Exercise Colds/Flu Flying

Does anything else make you worse? ____

What medicines have you tried for your symptoms? Did they work? ______________________________

____

____

Have you tried Claritin? If so, did it work? ____

Have you tried Zyrtec? If so, did it work? ____

Alcohol Use –

Do you drink alcoholic beverages? ☐ **Yes** ☐ **No**

Number of drinks/day: _________ ☐ **Beer** ☐ **Wine** ☐ **Liquor**

(Alcohol Serving = 12 oz. beer, 6 oz. wine or 1 ½ oz. liquor)

Drug Use –

Do you use marijuana or recreational drugs? ☐ **Yes** ☐ **No**

Richard R. Rosenthal, M.D., LTD
Patient Questionnaire

Patient Name: ____ **Date:** _________________________________

Tobacco Use –
Do you smoke cigarettes? ☐ **Current** ☐**Former** ☐**Never**
(If you never smoked go to Family History questions now.)

Former Smoker: Quit date: ______ **How many years did you smoke?** _______

Approximately how many packs a day did you smoke? ______

Current Smoker: _____ **Packs/day** _______ **Number of Years**

Other Tobacco: _____**Pipe** _____**Cigar** _____**Snuff** _____**Chew**

Passive Smoke Exposure

☐Currently exposed to second hand smoke
☐ Formerly exposed to second hand smoke (describe)____

Exercise –

Do you exercise? What and how often? ____

Family History – **Indicate which relative has had the following diseases (parents and siblings are most important).**

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
Hay Fever										
Asthma										
Eczema										
Hives										
Emphysema										
Cystic Fibrosis										
Immune Problems										

Past Medical History:

Have you ever had a bad reaction to insect stings, such as wasps or bees? ___________________________________

Are you allergic to any foods? If so, which ones? ____

Have you ever had hives? ____

____

____

Richard R. Rosenthal, M.D., LTD
Patient Questionnaire

Patient Name: ____ **Date:** ______________________________

Have you ever seen an allergist before? Who and When? ____

____

Have you ever been skin tested? When and what were you allergic to? _________________________________

Have you ever had allergy shots? When? ____

____

Have you ever seen an ear, nose and throat (ENT) specialist? When? ____________________________

____

Have you ever seen a pulmonologist? When? ____

____

Please list any medical problems, surgeries, hospitalizations, and/or serious injuries you have had and when they occurred as well as any chronic illnesses. ____

____

____

____

Date of your last chest x-ray: ________________________ **Sinus x-ray or CT-scan:** ______________________

Immunizations:

Vaccine Name	Date
Flu Vaccine	
Pneumonia Vaccine	

Do you travel often or internationally? ____

(Go to Environmental History Questionnaire on next page).

Richard R. Rosenthal, M.D., LTD
Patient Questionnaire

Patient Name: ____ **Date:** _________________________________

Environmental History Questionnaire

Home Environment:

Type of House: ______ Single Family ______ Apartment ______ Barracks ______ Dorm

Age of House: ______ Years Resident for how many years? _________

Surroundings: _______ Grass _______ Trees _______ Fields _______ Rivers/Streams

_______ Industrial Exposure _______ City Pollution _______ Animals

Ventilation:

Source of Fuel: ______ Gas ______ Oil ______ Electric

Type of Heating: _____ Forced _____ Hot Water _____ Radiant _____ Fireplace _____ Wood Stove

Air Conditioning: ______Central ______Room ______None ______

Humidification: _______Central ______ Area ______ Room Vaporizer ______None

Basement: ______ Below Grade ______ Part Below Grade ______Humidifier

Condition of Basement: _____ Storage ______Laundry ______Family Room ______Recreation Room

Environment: ______Plants ______Aquarium ______Smokers

Animals: ______ Cat ______Dog ______Hamster ______Gerbil ______ Fish _______Other

Animals allowed in bedroom: ______ Yes ______ No

Work Environment:

______ Enclosed Office ______ Cubicle ______ Open Desk ______ Outside

______ Classroom ______ other (please specify): ______________________

Work Hazards: _____ Smokers in the Office _____ Other Inhalants (please specify): _______________

Bedroom Furnishings:

Floor Coverings: ______ Rug ______ Wood ______ Tile

Rug type (if applicable): ______ Shag ______ Loop ______ Pile ______ Rug Pad

Window Coverings: ______ Curtains ______ Shades ______ Venetian Blinds

Pillow: ______ Feather ______ Foam ______ Synthetic ______ Age **of Pillow**

Mattress: ______ Innerspring ______ Foam _____ Water ______ Age **of Mattress**

Springs: ______ Box _____ pen ______

Bed Clothing: ______ Down ______ Wool _______ Cotton _______ Other

Collections in Bedroom: ______ Stuffed Animals ______ Books ______ Tapes/CDs

______ Plants ______Other (please specify): _______________________________________

Richard R. Rosenthal, M.D., LTD.
Review of Systems

Patient Name: ____ **Date:** _________________________________

The following is a general list of some symptoms. Please circle any that you have and we will discuss them when you come in to see us.

GENERAL: Fevers Chills Sweats Loss Of Appetite Fatigue Malaise (Lack Of Well Being) Weight Gain Weight Loss Night Sweats

EYES: Itching Blurring Double Vision Irritation Discharge Vision Loss Eye Pain Photophobia (Difficulty With Light) Watery Burning Red Eyes Glaucoma Cataracts

EARS: Earache/Pain Ear Discharge Tinnitus (Ringing In The Ears) Decreased Hearing Itching Ear Popping Frequent Ear Infections Plugging Tubes Placed In Ears

NOSE: Nasal Congestion Nasal Discharge Nasal Stuffiness Sneezing Itching Nosebleeds Snoring Loss Of Smell Polyps Frequent Sinus Infections

THROAT: Post Nasal Drip Sore Throat Hoarseness Itching Loss Of Taste Difficulty Swallowing

RESPIRATORY: Cough Shortness Of Breath Excessive Sputum Wheezing Chest Tightness

CARDIOVASCULAR: Chest Pain Palpitations Fainting Peripheral Edema (Swelling of Lower Extremities) Orthopnea (Difficulty Breathing When Lying Down) Irregular Heart Rhythm

GENITOURINARY: Dysuria (Painful Urination) Hematuria (Blood In The Urine) Frequency Of Urination Urgency Nocturia (Urination At Night) Poor Stream Flow History Of Prostate Problems

GASTROINTESTINAL: Gas Pain Heartburn Nausea Diarrhea Constipation

MUSCULOSKELETAL: Back Pain Joint Pain Joint Swelling Muscle Cramps Muscle Weakness Stiffness Arthritis

SKIN: Rash Hives Scaly Patches Eczema Itching Dryness Suspicious Lesions

NEUROLOGIC: Headache Weakness Seizures Fainting Tremors Dizziness Lightheadedness Paresthesias (Pins And Needles Sensations)

PSYCHIATRIC: Depression Anxiety Memory Loss Mental Disturbance

ENDOCRINE: Cold Intolerance Heat Intolerance Excessive Thirst Excessive Hunger History of Thyroid Disease Diabetes Hormone Replacement Therapy

HEMATOLOGIC: Abnormal Bruising Bleeding Enlarged Lymph Nodes Anemia

Richard R. Rosenthal, M.D., LTD.
Medications

Patient Name: ____ **Date:** ______________________

Please list all medications that you take, including prescription and over-the-counter medications, such as aspirin, Advil, nutritional supplements, vitamins, etc. Write in the information below as listed on your medication container.

MEDICATIONS YOU ARE ALLERGIC TO: ____

Medication ____________________________ Strength/Dose ________________ Frequency ____________
Reason _______________________________ How Long ____________________

Medication ____________________________ Strength/Dose ________________ Frequency ____________
Reason _______________________________ How Long ____________________

Medication ____________________________ Strength/Dose ________________ Frequency ____________
Reason _______________________________ How Long ____________________

Medication ____________________________ Strength/Dose ________________ Frequency ____________
Reason _______________________________ How Long ____________________

Medication ____________________________ Strength/Dose ________________ Frequency ____________
Reason _______________________________ How Long ____________________

Medication ____________________________ Strength/Dose ________________ Frequency ____________
Reason _______________________________ How Long ____________________

Medication ____________________________ Strength/Dose ________________ Frequency ____________
Reason _______________________________ How Long ____________________

Please list additional medications on the back if needed.