Valley ENT
ASSOCCIATES, P.C.

Ear, Nose and Throat
Sinus, Allergy, and Hearing Aid Services
(989) 799-8620

ALLERGY PATIENTS

Please call your health insurance customer service number **BEFORE** your allergy testing appointments. It is **YOUR** responsibility to understand your coverage and to obtain a referral if needed.

The following are the codes your insurance carrier will request:
Procedure Code: 95027 and 95004   Diagnosis Code: J30.1

Allergy testing is not always a covered benefit under insurance. If it is a covered benefit by your insurance, balances may be transferred to you if you have not met your deductable.

We will contact you with deductible/benefit information if applicable.

Deductible balances will be due before allergy testing or allergy serum appointments.

If balances are not paid by ________________, your allergy testing/allergy serum appointments will have to be canceled. We will reschedule when balances are received.

I understand that I am responsible for all charges not covered by my insurance. I understand that I am required to give a 24 hour notice of cancellation so that another patient can fill the vacancy.

Failure to notify Valley ENT within 24 hours will necessitate a $50.00 missed appointment charge.

____ ______________
Print Patient Name   Date of Birth

____ ______________
Print Responsible Party's Name   Date

Appointment Date and Time: ____

Recommended for Ages 13 and Under

PLEASE FOLLOW THESE INSTRUCTIONS IF USING LMX (Lidocaine 4% or 5%) CREAM

1. Apply cream to outer surface of the upper arm from the armpit line to just above the elbow. Apply to an area approximately 3 inches wide by 6 inches long. It will look like frosting.

2. We do **not** test on any tattoo or sunburn. Do **not** rub cream in. Allow it to remain in a thick layer.

3. Apply cream 1 hour before your testing appointment.

4. Wrap the cream covered arm comfortably with a plastic wrap. Be careful not to slide the cream to one side. Wrapping the arm prevents cream from drying out, allows for better absorption into the skin, and keeps cream from getting onto clothing. Place a small piece of tape at the top and bottom to prevent the wrap from sliding.

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Keith E. Scharf, MD
Brian F. Perry, MD
Jeffrey S. Milewski, DO

Sinus Disease
Sleep Disorders
Laser Surgery
Allergy Evaluation
Voice Disorders

Jayne M. Metro, MA, CCC-A

Audiology
Hearing Aid Sales
and Service
Balance Testing
and Rehabilitation

Allergy Testing Instructions

An appointment has been made on ______________ at __________ AM/PM for intradermal skin testing.

IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT, YOU MUST NOTIFY US AT LEAST 24 HOURS IN ADVANCE; OTHERWISE A CHARGE OF $50.00 WILL BE MADE. If this date conflicts with previous plans, please notify us immediately at (989) 799-8620.

1. Do **not** take any antihistamines such as Zyrtec, Allegra, Claritin, Benadryl, Actifed, Chlor-Trimeton, etc. for 7 days before your appointment.
2. You may continue to take decongestants such as Sudafed.
3. You may continue to use your nasal spray such as Nasacort, Rhinocort, Nasonex, Flonase, Dymista, Qnasl, or nasal saline.
4. **TESTING CANNOT BE DONE** if you are taking a Beta Blocker such as Inderal (propranolol), Lopressor(metoprolol), Blocarden (timolol), Corgard (nadolol), Normodyne (labetalol), Visken (pindolol), Ocupress (carteolol), Betapace (sotalol), etc. (If your blood pressure medication ends with –lol, it is a Beta Blocker). Please supply us with an accurate list of **all** medications you are taking or have taken 2 weeks prior to your allergy testing. Consult your physician to substitute any Beta Blocker medications during allergy testing.
5. Please complete the allergy questionnaire and bring it to your appointment.
6. Inform us if you have asthma, wheezing, or a fever.
7. Do not change your diet before the test.
8. Make sure you eat breakfast before coming to a morning appointment, and lunch before an afternoon appointment.
9. Please wear short-sleeved or sleeveless (preferred) apparel.
10. Please be careful **not** to get sunburned on your arms before testing. Testing **cannot** be completed on sunburned skin.
11. The testing appointment may take 1 to 2 hours. Afterward, you will see the doctor to discuss the results.
12. If an unusual symptom such as sneezing, coughing, itching, hives, or asthma occurs after the allergy testing, please contact our office.
13. **INFORM US IF YOU ARE PREGNANT** or if you believe you may be pregnant. **IT IS IMPORTANT THAT YOU INFORM US** if you have tested positive for hepatitis or the HIV virus (AIDS), or if you believe that you may be in a category at risk for contracting AIDS. If you are not sure if you are in a risk category for contracting AIDS, please ask us. Allergy treatment should not be given to a person with the HIV virus or pregnancy because of the possible serious adverse effects it may have.

SOME OF THE COMPLICATIONS OF ALLERGY TESTING INCLUDE, BUT ARE NOT LIMITED TO, ITCHING, REDNESS, OR LOCALIZED SWELLING OF THE ARMS.

PLEASE CHECK WITH YOUR INSURANCE COMPANY REGARDING COVERAGE. YOU WILL BE HAVING INTRADERMAL TESTING.

Procedure code: 95027 and 95004

Diagnosis code: J30.1

Please do **not** wear any cologne or perfume the day of testing. Thank you.

2551 McLeod Drive South • Saginaw, MI 48604-2827 • Phone: (989) 799-8620 • Fax: (989) 799-2664 • www.valleyentsaginaw.c

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ALLERGY PAITENTS

Please Complete & Bring to Appointment

Name: ______________________ Today's Date: ____________

Date of Birth: ______________________

Person to be called in case of emergency: Name: ______________________

Relationship to patient: ______________________ Telephone ____________

Please study each question carefully and answer it as completely as possible:

Yes **No**

_____ _____ Cough? Constant _____ Intermittent _____ Daytime _____ Nighttime _____

_____ _____ Frequent colds or Upper Respiratory Infections?

_____ _____ Sneezing? What precipitates it? ______________________

_____ _____ Sore Throats? Frequency: ______________________

From Infections? Yes _____ No _____

From Drainage? Yes _____ No _____

_____ _____ Nose Drainage? From the front _____ Down the throat _____

Drainage is... Clear _____ Colored _____ Thick _____ Thin _____

Drainage from... Left side _____ Right side _____ Both Sides _____

_____ _____ Nose Blockage? Left side _____ Right side _____ Both sides _____

_____ _____ Eye symptoms? Burning _____ Puffy _____ Watery _____

Eyes itching? Yes _____ No _____

_____ _____ Wheezing? Now? _____ As a child? _____ With exercise? _____

Out in the cold? _____ With infections? _____

Other things that cause wheezing? ______________________

Yes	No	
____	____	Headaches? Which part of the head? ____________
		What starts a headache? ____________
		What makes it worse? ____________
		Are your headaches worse at any time of the day? ____________
		Can you tell when a headache is about to start? ____ How? ____________
____	____	Fatigue? When? Certain times of the day? ____________
		After eating? ____ Certain days of the week? ____ When? ____________
____	____	Short of breath? Do you know why? ____ Explai n: ____________
____	____	Asthma? Now? ____ As a child? ____
____	____	Have you ever had to go to the hospital for an asthma attack?
____	____	Do you get sinus infections?
____	____	Earaches? Do you experience any of the following ear problems: Itching? ____
		Flaking? ____ Stuffy? ____ Ringing? ____ Buzzing? ____ Crackle? ____ Hearing Loss? ____
____	____	Vertigo (dizziness)? When? ____________
____	____	Loss of smell? When? ____________
____	____	Loss of taste? When? ____________
____	____	Eczema? Now? ____ As a child? ____ Describe the type and location: ____________
		____________
____	____	Hives? When? ____ Where? ____ Specify: ____________
____	____	Do you know of anything that causes you to have hives or a rash?
		Soap? ____ Ointments? ____ Clothing? ____ Cosmetics? ____ Poison Ivy? ____
____	____	Pets? Kind: ____________ Kept inside or outside? (circle one)
		Breed: ____________ How long have you had your pet? ____________
		Symptoms worse when visiting friends who have pets? Yes ____ No ____
		Any animal contact that causes symptoms? ____________
____	____	Do you smoke? Cigarettes? ____ Cigars? ____ Pipe? ____
		Chew tobacco? ____ Snuff? ____

Yes	No	
______	______	If you do not smoke, does someone else's smoke bother you?
______	______	Itchiness? Nose? _____ Roof of mouth? _____ Ears? _____ Hands? _____ Feet? _____
______	______	As an infant, were you taken off formula or any foods? Specify: ______
______	______	Have you ever experienced anxiety or panic attacks? Are you being treated? ______
______	______	Have foods ever caused an allergic reaction? Hives? ______ Rash? ______ Wheezing? ______ Swelling? ______ Difficulty Breathing? ______ List the food(s): ______
______	______	Do your symptoms improve, get worse, or stay the same when on vacation? (circle one) Where do you usually go on vacation? Mountains, seashore, other ______

Do your symptoms increase or decrease with the following conditions:

Increase	Decrease	Same	
______	______	______	Cold Weather
______	______	______	Warm Weather
______	______	______	Air conditioning
______	______	______	Windy Days
______	______	______	March to May
______	______	______	May to July
______	______	______	August to October
______	______	______	November to March
______	______	______	Damp weather
______	______	______	Housework (dusting, etc.)
______	______	______	Change of seasons
______	______	______	When the furnace goes on
______	______	______	Going to bed
______	______	______	After asleep for a short time
______	______	______	Upon arising
______	______	______	Later in the day, 4:00 pm to 9:00 pm
______	______	______	Mowing the grass

Home and Work Environment

What is your occupation? ______________________________

Do you participate in any particular activities, hobbies or recreation? ______________________________

Please specify: ______________________________

(Please specify by "H" for home and "W" for work)

Are your symptoms increased at home, work, or no change? (circle one)

Are you exposed to excessive amounts of dust, fumes, chemicals, or noise? ______________________________

Are there plants, dried flowers, or fresh flowers at home or work? ______________________________

Heating system: Electric ______ Gas ______ Oil ______ Propane ______ Kerosene heater ______ Force Air ______

Hot Water ______ Air cleaner ______ Humidifier ______

Cooking: Gas ______ Electric ______ Propane ______

Housing: Do you live in a house? ______ Two story ______ Split level ______ Ranch ______ Trailer ______

Do you live in an apartment? ______ Small building ______ Large building ______ Older building ______

Newer building ______ Have you had insulation blown into your house? ______

Furniture: Upholstered ______ Not upholstered ______ Fabric ______ Vinyl ______ Other ______

Family History

Have any of your blood relatives had any of the following illnesses? If so, underline and check the relationship.

	Father	**Mother**	**Brother**	**Sister**	**Child**
Bronchial Asthma					
Emphysema					
Hay Fever					
Sinus Infections					

How long have you had the symptoms that brought you to our office?

Years ______ Months ______ Weeks ______ Days ______

Have you had allergy testing before? Yes ______ No ______ Date of last testing: ______________

Type of testing: Scratch, Intradermal, RAST (circle one)

Were there positive reactions? Yes ______ No ______ To what? ______________

Were you on allergy shots? Yes ______ No ______ How long? ______________

Did you improve with treatment? Yes ______ No ______

List all prescription and over-the-counter medications you are taking or have taken in the last week: ______________

____

Do you have any allergies to medications? Yes ______ No ______ Specify: ______________

____

Please give any other information that is pertinent to your symptoms: ______________

____

____