Valley ENT
ASSOCIATES, 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: ____

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.

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.

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

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
(989) 799-8620

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? ______________________

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? ______ Explain: ______

______ ______ 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? ______

______ ______ 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

(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: ______________________________

____

____