

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

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PATIENT REGISTRATION

Name of Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail address: _____ Fax Number: _____

Home Telephone: _____ Work Telephone: _____

Date of Birth: _____ Age: _____ Sex: Male ___ Female ___ SS#: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Employer: _____ Your Occupation: _____

Primary Care Physician: _____ Address: _____

Primary Care Physician Telephone Number: _____ Fax Number: _____

Referring Physician: _____ Address: _____

Referring Physician Telephone Number: _____ Fax Number: _____

Person to Contact in Emergency: _____ Relationship: _____ Phone: _____

Party Responsible for Payment: Self ___ Spouse ___ Parent ___ Other ___

Name of Responsible Party (if other than self) _____

Address of Responsible Party (if different than listed above): _____

City: _____ State: _____ Zip Code: _____

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

Insured Party: Self ___ Spouse ___ Parent ___ Other ___

ID#/Social Security Number: _____ Group/Plan #: _____

Name of Insured Party (if other than self): _____

Address of Insured Party (if other than self): _____

City: _____ State: _____ Zip Code: _____

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

Insured Party: Self ___ Spouse ___ Parent ___ Other ___

ID#/Social Security Number: _____ Group/Plan #: _____

Name of Insured Party (if other than self): _____

Address of Insured Party (if other than self): _____

City: _____ State: _____ Zip Code: _____

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:** _____

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Patient Questionnaire

Please complete this form and bring it to your appointment. We will review it when you come into the office.

-Thank you!

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? _____

Do you smoke? _____ Never _____ Previous _____ Current/Date Started _____ Date Quit _____ Quantify _____

Do you drink alcoholic beverages? _____ No _____ Yes **If YES: (Circle one) Occasional 1/day 2-3/day 4+/day**

Do you exercise? What and how often? _____

Do you have any family history of: Hay Fever Asthma Eczema Hives Emphysema
Cystic Fibrosis Immune Problems

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Patient Questionnaire

Patient Name: _____ **Date:** _____

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? _____

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:** _____

Date of your last flu shot: _____ **Pneumonia vaccine:** _____

Do you travel often or internationally? _____

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Environmental History Questionnaire

Patient Name: _____ **Date:** _____

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 _____

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): _____

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Review of Systems

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

PATIENT NAME: _____ DATE: _____

PLEASE LIST **ALL** MEDICATIONS THAT YOU TAKE, INCLUDING ASPIRIN, ADVIL, NUTRITIONAL SUPPLEMENTS, VITAMINS, ETC. WRITE IN THE INFORMATION BELOW AS PRINTED ON YOUR 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 _____

Medication _____ Strength/Dose _____ Frequency _____

Reason _____ How Long _____

Please list additional medications on the back if needed.

RICHARD R. ROSENTHAL, M.D., LTD.
Adult and Pediatric Allergic Disease, Asthma and Immunology

Office Policy

Thank you for choosing our office as your specialist provider. 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. You will also be asked to sign a receipt that you have received our "Notice of Privacy Practices."

Regarding Insurance

A patient's health insurance is a contract between the patient and their insurance company. As such you are responsible for understanding your policy reimbursement requirements. If your health insurance is with a company with which we participate 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 each claim 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. There is an administrative fee of \$5.00 for any additional billing statements.

Most Health Maintenance Organizations (HMO) require a patient to have a referral from 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/Discover as payment.

Usual and Customary Rates/Interest

Our fees are considered usual and customary for our specialty in the Washington, D.C. geographic 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 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(s). 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.

Consent for Disclosure of Personal Health Information (PHI)

Please see our "Notice of Privacy Practices" that explains how information about you may be used or disclosed.

Information about you may be seen by other patients when you use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician. There is also a sign up sheet for allergy injections where your name may be viewed by others. We may call you by name when it is time for you to receive medical services in our office. We may use or disclose information about you in contacting you regarding an appointment. We may send you a postcard to remind you that you are due for a recall appointment with one of our doctors.

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.

Signature of Patient or Responsible Party

Date _____

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