Great Lakes Allergy & Asthma Center, P.C.

PATIENT'S NAME: _____

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

Thank you for choosing the Great Lakes Allergy & Asthma Center for your health care needs! We have scheduled an appointment for you with Dr. Peter Ranta on the above date for an initial evaluation.

TO DO BEFORE YOUR VISIT

- Please fill out the enclosed forms and bring them with you when you come.
- Bring all of your insurance cards with you. Bring a Photo ID card (Driver's License, etc.)
- Bring all of your medications with you.
- Please call our office to confirm your appointment by the close of business the day before your appointment.
- Please ask your doctor to mail (or send with you) any medical information, tests, or recent X-ray or CT reports that might be helpful.

MEDICATIONS TO HOLD (they may interfere with skin testing)

- For **at least 7 days** before your appointment, please **do not take** any:
  - **"Anti-histamines"**
  - "Cold," "Allergy," "Cough," or "Sinus" medications
  - **Please see the attached lists for medications which must be stopped.**
- **Continue all of your asthma medications,** antibiotics, and other medications.
- Please remember to eat and drink as you normally would before your appointment.
- Exception: If you have severe hives or itching, continue to take your anti-histamines.

REGARDING PAYMENT

All co-pays and deductibles are due at the time of your visit with us.

METHOD OF PAYMENT

We accept cash (U.S. dollars), checks (Michigan), MasterCard and Visa (including Debit Cards).
Note: We do not accept Starter checks (checks without a name), Out-of-state Checks, or Canadian cash or checks.

SPECIAL CIRMCUMSTANCES

We realize that sometimes it is difficult to pay your balance immediately. If problems arise, contact our Billing Manager as soon as possible to arrange an appropriate plan.

DIRECTIONS

The Great Lakes Allergy & Asthma Center is located at 309 W. 12th Avenue, Suite 101.
It is in the "12th Avenue Professional Building" located on West 12th Avenue, 2 blocks West of the Dairy Queen traffic light from the I-75 Business Spur.

TIME REQUIREMENT

The initial evaluation usually requires several hours to complete, so please arrange your schedule appropriately.

- Please remember that even if you are self-referred, you need a primary care physician. We will send information to him or her so that we can work together for your best medical care.
- If you are unable to keep your appointment or are going to be running late, please call and notify us at **(906) 253-0400** as far in advance as possible. Thank you and we look forward to seeing you!

Sincerely yours,

Scheduling Secretary
Great Lakes Allergy and Asthma Center, P.C.

(rev. 8/18)

ANTI-HISTAMINES (Tablets, Chewables, Syrup, Nose sprays, and Eye drops)

Brand Names

Actifed® [OTC]
Aerius® [OTC Canada]
Alavert® [OTC]
Aler-Dryl® [OTC]
Alka-Seltzer® Plus Cold [OTC]
Allegra®
Allent®
Aller-Chlor® [OTC]
Allerest® [OTC]
AllerMax® [OTC]
Anaplex® [OTC]
Antihist-1®
Astelin®
Atarax®
Banophen® [OTC]
Benadryl® Allergy [OTC]
Benadryl® Dye-Free Allergy [OTC]
Benadryl® Gel [OTC]
Benadryl® Gel Extra Strength [OTC]
Benadryl® Injection
Bonine® [OTC]
Brofed® [OTC]
Bromfed® [OTC]
Bromfenex®
Children's Tylenol® Cold [OTC]
Clarinex®
Claritin® [OTC]
Chlo-Amine® [OTC]
Chlorafed® [OTC]
Chlor-Trimeton® [OTC]
Codimal® [OTC]
Compoz® Nighttime Sleep Aid [OTC]
Comtrex® Allergy-Sinus [OTC]
Contac® Severe Cold and Flu [OTC]
Co-Pyronil® [OTC]
Dallergy® JR
Dimetapp® [OTC]
Diphen® AF[OTC]
Diphen® Cough [OTC]
Diphenhist [OTC]
Dramamine® [OTC]
Dramamine® Less Drowsy Formula [OTC]
Drixoral ®[OTC]

Brand Names

Elestat®
Emadine®
Genahist® [OTC]
Hayfedrol® [OTC]
Histalet® [OTC]
Hydramine® [OTC]
Hydramine® Cough [OTC]
Hydrate®
Hyrexin-50® [OTC]
Iofed®
Klerist-D® [OTC]
Livostin®
Lodrane®
Marezine® [OTC]
Nolahist® [OTC]
NyQuil
Nytol® [OTC]
Nytol® Maximum Strength [OTC]
Optimine®
Optivar™
Pataday®
Patanase®
Patanol®
PBZ®
PBZ-SR®
Periactin®
Phenergan®
Polaramine®
Pseubrom®
Reactine® [OTC Canada]
Rhinosyn® [OTC]
Rondec®
Siladryl® Allergy [OTC]
Silphen® [OTC]
Sinutab® Sinus Allergy [OTC]
Sleepinal® [OTC]
Sominex® [OTC]
Sominex® Maximum Strength [OTC]
Tavist®
Tavist®-1
Thera-Flu® Flu and Cold [OTC]
Triaminic® [OTC]
TripTone® [OTC]
Tussionex®

Brand Names

Tusstat® [OTC]
Twilite® [OTC]
Tylenol Allergy Sinus [OTC]
Ultrabrom®
Unisom® SleepGels [OTC]
Vistaril®
Zaditor [OTC]®
Zyrtec®

Generic Names

Azatadine
Azelastine
Brompheniramine
Cetirizine
Chlorpheniramine
Clemastine
Cyclizine
Cyproheptadine
Dexchlorpheniramine
Dimenhydrinate
Diphenhydramine
Fexofenadine
Hydroxyzine
Ketotifen
Levocabastine
Loratadine
Olopatadine
Phenindamine
Promethazine
Tripelennamine

Note: Any 'Cold', 'Allergy', 'Cough', or 'Sinus' over-the-counter medication will likely have anti-histamines.

(rev. 8/15)

Peter M. Ranta, M.D., 309 W 12th Ave., Suite 101, Sault Ste. Marie, MI 49783 Ph: (906) 253-0400

Great Lakes Allergy & Asthma Center, P.C.

Patient Correspondence Information

Patient's Name: _____

Date of Birth: _____

1. Please list the person or people with whom we may inform about laboratory and X-ray results, general medical condition, diagnosis, appointments, prescription drugs, or other health care information. An example would be parents, grandparents, etc.

   Name: _____ Phone #: (____)_____

   Name: _____ Phone #: (____)_____

   Name: _____ Phone #: (____)_____

2. Please print the address of where you would like your billing statement and/or correspondence from our office to be sent. E-mail is optional; we would use this to notify you for emergency cancellations.

   Address: _____
   STREET/ P.O. BOX

   _____
   CITY STATE ZIP CODE E-MAIL

3. Can confidential messages (lab results, etc.) be left on your telephone answering machine or voice mail?

   ____ Yes ____ No If yes, Phone #: (____)_____
   * I am fully aware that a cell phone is not a secure and private line.*

4. To optimize the patient's health care, we share information (labs, X-rays, etc.) concerning the patient with the patient's Primary Care Physician.

   Primary Care Physician: _____

   Address: _____City, State, Zip_____

   Phone #: (____)_____

5. I hereby agree to pay for services rendered to me at Great Lakes Allergy and Asthma Center, P.C. I authorize my insurance benefits to be paid to the Great Lakes Allergy and Asthma Center, P.C. I realize that I am financially responsible for charges not covered by this assignment, services which may be considered by my insurance plan to be non-covered or included in another service, or charges for services with an appropriate referral/authorization by my primary care physician when required by my insurance.

   I further understand that failure to keep an appointment and/or failure to promptly resolve my account balance may result in additional charges being added to my account. A late charge of $20 covers the cost of re-billing and manual processing. The missed appointment charge is $20. If my account is sent to a collection agency, I understand that this will result in additional charges being added to my account. Late charges, missed appointment charges, and collection agency charges are not covered by my insurance carrier and are my responsibility. I hereby authorize the release of any pertinent medical information to insurance carriers.

   Patient/ Parent or Guardian Signature: _____ Date: _____

Rev. 8/15

Great Lakes Allergy & Asthma Center, P.C.

New Patient Questionnaire

Patient Name: _____

Date of Birth: _____

Parent's name (if child): _____

REGULAR PHYSICIAN: _____
PHYSICIAN'S ADDRESS: _____

_____

OTHER PHYSICIANS YOU SEE: _____

WHAT IS THE MOST IMPORTANT PROBLEM: (Please describe)

_____

_____

Other symptoms that bother you: (Please describe)

_____

Have you noticed things that make this problem better? _____
Have you noticed things that make this problem worse? _____

MEDICATIONS: (Please bring <u>all</u> of your medications with you) Please list below or attach your own list:

Medications	**Dose**	**How often**	**Medications**	**Dose**	**How often**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ENVIRONMENT:

<u>Please Check everything that applies to your home</u>:

Age of Home: ____ years old ___Wood ___ Brick ___ Modular ___ Mobile home ___ Apartment
Does your home have mold or water damage? ____Yes ____No
If yes for mold, where? ___ Basement ___ Bathroom ___ Windows ___ Ceiling Other: _____

Flooring found in your home: ___ Carpeting ___ Linoleum ___ Tile ___ Hardwood/Laminate
Foundation of your house: ___ Basement ___ Crawlspace ___ Slab
In your bedroom, do you have: ___ Stuffed toys ___ Feather Pillows ___ Down Comforters

Heating: ___ Gas Central Forced Air ___ Gas Hot Water ___ Electric Baseboard ___ Fuel Oil
___ Indoor Wood Stove ___ Outdoor Wood Stove
Do you have: ___ Humidifier ___ Dehumidifier
How many Pets: ___ Indoor Dogs ___ Outdoor Dogs ___ Indoor Cats ___ Outdoor Cats ___ Birds
Other pets: _____

Do you Smoke? ____Yes, if yes, how many packs a day? _____ How old were you when you started? _____
____No ____ I quit smoking, what year? _____
Do any family members smoke? ___Yes ___No; If yes, who smokes? _____ ___ Indoors ___ Outdoors

DIET:
Any Food Allergies? ____Yes ____No
Describe any reactions to foods: _____
Currently on special diet? ____Yes ____No Describe:_____

PAST MEDICAL HISTORY:
Have you ever seen an Allergy doctor? ____Yes ____No Name of Allergy doctor: _____
Have you ever been on allergy shots? ____Yes ____No If yes, for how many years? _____
Any Medication Allergies (Please describe) _____
_____
Insect sting reactions: (Please describe) _____
_____
Immunizations up to date? ____Yes ____No Describe any reactions:_____
List other Medical Illnesses: _____
_____
List previous Surgeries: _____
_____
Previous injuries to nose? ____Yes ____No

FAMILY HISTORY OF PATIENT:
Please Circle Yes or No in each box for family members:

	Father	Mother	Brother	Sister	Son	Daughter	Grand-father	Grand-mother
Asthma	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Nose allergies	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Eczema	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Frequent serious infections	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Swelling lips, tongue	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Hives	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Lupus	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Thyroid disease	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

SOCIAL HISTORY OF PATIENT:
Who lives at home? _____
Patient's occupation: _____
Grade in school _____
Attends day-care? ____Yes ____No If yes for daycare, how many days a week? _____