

Institute for Asthma and Allergy

11002 Veirs Mill Road, Suite 414
Wheaton, MD 20902-2538
Tel (301) 962-5800
Fax (301) 962-9585



5454 Wisconsin Avenue, Suite 700
Chevy Chase, MD 20815-6901
Tel (301) 986-9262
Fax (301) 907-7910

Michael A. Kaliner, MD Martha V. White, MD Athena Economides, MD H. Henry Li, MD, PhD Mark D. Scarupa, MD Eyal Oren, MD

Dear New Patient:

Thank you for selecting the Institute for Asthma & Allergy for your medical needs. On behalf of our physicians and staff we would like to welcome you to our Wheaton office.

On the day of your first appointment please be prepared to stay two hours or more. Our goal is to make each of your visits, from first to last, as effective, efficient and pleasant as possible. The following guidelines will help us to achieve this goal:

- 1) Please arrive 15 minutes prior to your appointment time to complete the registration process. It will help to expedite registration if you will verify the information on the guarantor's profile sheet and complete the registration form that is enclosed.
- 2) Be sure to have your insurance card and a picture identification with you. Your insurance will be verified and any co-pay or deductible will be collected prior to service. (For your convenience we accept cash, check, MasterCard or Visa).
- 3) If you are insured by an H.M.O. you must have a valid referral form from your primary care physician with you. Failure to bring a referral may result in having to reschedule your appointment.
(*Special Note* it usually takes at least 48 hours to obtain a referral, so be sure to plan ahead.)
- 4) Please refrain from using any oral antihistamine for 72 hours prior to your visit. We have enclosed a list of antihistamines for your convenience. Failure to comply will result in the postponement of any needed skin testing.
***If you are taking any asthma medication or antibiotics, please continue as prescribed. ***
- 5) As a courtesy to our other asthma and allergy patients we ask you to refrain from using any scented products on the day of your visit. These products may cause a negative reaction in some patients.
- 6) For your convenience, our staff makes appointment reminder calls 1-3 days prior to your scheduled visit. All cancellations need to be made 24 hours in advance. If the office is closed, you may leave a cancellation message with our answering service. We have a missed appointment fee for failure to comply.
- 7) Please find a map of the area enclosed. Parking is available free of charge. The Red Line Metro is also located in the Parking lot for your convenience. (Wheaton Plaza Metro Stop)

We look forward to meeting you. Should you have any questions please call (301-962-5800) during normal business phone hours.

Monday - Thursday	7:00am to 12:00 noon	1:00pm to 5:00pm
Friday	7:00am to 12:00 noon	1:00pm to 5:00pm
Saturday	8:00am to 12:00 noon	

Thank you,
The Physicians and staff of the Institute for Asthma & Allergy

**Directions to the Institute's Wheaton Office: 11002 Veirs Mill Road
Suite 414
Wheaton, Maryland
Phone: 301-962-5800**

From Virginia:

Beltway 495 to exit 33 North. Take a left off of the exit (Connecticut Avenue north toward Kensington). Go North on Connecticut Avenue staying in the right hand lane. Follow Connecticut Avenue north it will turn into University Blvd. Continue north on University Blvd. Approximately $\frac{1}{2}$ mile, make a right into Westfield Shoppingtown. Continue right onto the service road and follow around until you see Westfields South Tower located across from the parking garage at JC Penney.

From District of Columbia:

Take North Capital Street north, it will turn into Blair Road and then into Eastern Avenue. Turn right onto Georgia Avenue (heading north). Follow Georgia Ave. approx. 6 miles to Veirs Mill Road on your left. Turn Left onto Veirs Mill Road and Westfields South Tower (Westfield Shoppingtown) is on the Left across from the JC Penney covered parking lot.

From I-270:

Follow I 270 to the split and take 495 toward Baltimore, follow 495 to Exit 33 Connecticut Avenue north toward Kensington. Stay in the right lane, Connecticut will turn into University Blvd. Follow University Blvd. Approx. $\frac{1}{2}$ mile and make a right into Westfield Shoppingtown. continue right onto the service road. Follow the service road around to Westfield South Tower.

From Columbia Maryland:

Go South on Rt. 29 Turn Right onto Randolph Road follow to Georgia Ave and turn left onto Georgia Ave. From Georgia Avenue turn right onto University Blvd. then left into the Westfield Shoppingtown Mall. Follow road around to Westfields South Tower across from Covered Parking at DSW and JC Penny.

From Bowie/Annapolis:

US 50 West to Beltway 495. 495 to Georgia Avenue/Wheaton exit. Proceed north 1 mile to Veirs Mill Road on the left. Turn Left onto Veirs Mill Road and follow to Westfields South Tower located across from the parking garage at JC Penny and DSW .

From Rockville area:

Take Veirs Mill Road south to Westfield's Shoppingtown Mall. Take the Mall entrance just south of the intersection of Veirs Mill and University. Follow the service road around to Westfields South Tower next to covered parking next to JC Penney.

From Takoma Park:

University Blvd. North to Westfield Shoppingtown Mall. Turn onto Veirs Mill Road and follow to Westfield South Building located on the Westfield Mall property .

From Chevy Chase Office:

Wisconsin Avenue left on Western Avenue, follow Western to the Connecticut Avenue Circle, round the circle and go north on Connecticut Ave. Follow Connecticut Ave. north going under 495 Beltway toward Kensington. Continue on Connecticut Avenue in the right hand lane and that will turn into University Blvd. Follow University Blvd. to Westfield Shoppingtown and turn to the right, continue right around the service road to Westfield South Tower across from covered parking by JC penney.

From Wheaton Metro Stop:

Exit Metro to left take overpass to Westfields Shoppingtown Mall, pass JC Penney's on right, walk to end of Mall Parking garage, Westfield South Tower is on the Left.

Antihistamines

Discontinue at least 3 days prior to visit except as noted below

Accuhist	Periactin
Actifed with codeine cough syrup	Phenergan
Alavert <u>Discontinue 7 day prior to visit</u>	Rynatan
Allegra <u>Discontinue 7 day prior to visit</u>	Rondec and Rondec D
Allegra D <u>Discontinue 7 day prior to visit</u>	Sinulin
Allerx	Tavist D
Allerx D	Tamaril
Atarax <u>Discontinue 7 day prior to visit</u>	Trinalin
Atrohist	Tussend
Benadryl	Tussionex
Biohist	Tylenol PM
Bromfed	Semprex and Semprex D
Brompheniramine	Sinequan
Carbinoxamine	Viravan
Chlorpheniramine	Vistaril <u>Discontinue 7 day prior to visit</u>
Chlor-Trimeton	Zyrtec <u>Discontinue 7 day prior to visit</u>
Clarinet <u>Discontinue 7 day prior to visit</u>	Zyrtec D <u>Discontinue 7 day prior to visit</u>
Claritin <u>Discontinue 7 day prior to visit</u>	
Claritin D <u>Discontinue 7 day prior to visit</u>	
Clemastine	
Cyproheptadine	
D.A. Chewables	
Dimetapp Cough Syrup	
Doxepin	
Dura-Tuss	
Dura-Vent	
Extra Strength Pain Reliever/Sleep Aid	
Extendryl	
Hydroxyzine <u>Discontinue 7 day prior to visit</u>	
Kronofed	
Loratadine <u>Discontinue 7 day prior to visit</u>	
Nolahist	
Palgic	
PBZ Tablets	

If you have any questions regarding medications not listed, please contact your local pharmacy for further assistance to see whether it's an antihistamine.



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Please Print Clearly

Today's Date: _____

PATIENT INFORMATION

Patient Name		Home Phone #	
Home Address		City, State, Zip Code	
Social Security Number	Birthdate	Age	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep
Drug Allergies, if any			
Patient Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student			
Employer		Occupation:	
Business Address		City, State, Zip Code	Business Phone, Ext.

RESPONSIBLE PARTY

Responsible Party's Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other (<i>specify</i>)			
Name		Home Phone #	
Address		City, State, Zip Code	
Social Security Number	Birthdate	Age	
Employer		Occupation	
Employer Address		Business Phone, Ext.	
Person responsible for payment, if not same as above:		Home Phone #	
Home Address		City, State, Zip Code	

INSURANCE INFORMATION

Primary Insurance Company Name		Address	
Effective Date	Group #	Policy #	
Name of Policy Holder		Relationship to Patient	
Secondary Insurance Company Name		Address	
Effective Date	Group #	Policy #	
Name of Policy Holder		Relationship to Patient	
Name of Primary Care Physician		Phone #	
Address		City, State, Zip Code	

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that if this balance is not paid in a timely fashion, that I will be responsible not only for the balance due but any collection and/or reasonable attorney fees that are incurred in the attempt to collect this debt.

Print Name _____ Signature _____
Date _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to
The Institute for Asthma and Allergy for any services furnished to me by that physician.
I am aware that after 45 days, the outstanding balance becomes my responsibility and
the balance will be made in full unless other arrangements are made with the Billing Office.

Signature of Patient: _____ Date: _____

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POLICYHOLDER QUESTIONNAIRE

Due to recent HIPAA requirements, all of our patients are being asked to complete this form.

Please Print Clearly

Patient's Name: _____

Insurance Identification/Policy Number: _____

Name of Insurance Company: _____

1. Is the above insurance information NEW? Yes* No

*if you answered Yes to the above, please update your current information with the front desk.

2. Name of Policy Holder: _____

3. Relationship of Policy Holder to the Patient (check one):

- Mother Father Self
 Husband Wife Other:

4. Policy Holder's Employer: _____

5. Policy Holders Date of Birth: ____ / ____ / ____

Signature of Patient/Legal Guardian

Date

Name of Patient (if a minor)

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MEDICAL RECORDS RELEASE

I, _____, authorize the physicians of the Institute for Asthma and Allergy to report their medical findings to my Primary Care physician and/or other physicians or medical facilities that are deemed medically necessary for management of my healthcare.

I give permission for the physicians of the Institute for Asthma and Allergy to request my medical information from other specified physicians or institutions who may currently be providing care or may have provided treatment in the past.

I give permission for the mutual release of my medical or financial information associated with the Institute for Asthma and Allergy, specified insurance companies, attorneys or other agencies for billing, insurance coverage and/or financial concerns.

Signature of Patient/Legal Guardian

Date

Name of Patient (if a minor)

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EMERGENCY CONTACT

Patient's Name: _____

1. Name: _____
Relationship: _____
Telephone: _____ (home/work/cell)
Telephone: _____ (home/work/cell)

2. Name: _____
Relationship: _____
Telephone: _____ (home/work/cell)
Telephone: _____ (home/work/cell)