Ulrich Ringwald, MD
Director: Allergy & Asthma Center of Rochester
Chief of Allergy: Beaumont Hospital, Crittenton Hospital
Board-Certified: American Board of Allergy & Immunology, American Board of Internal Medicine, Michigan State Board of Medicine
Fellow: Allergy & Immunology, Henry Ford Hospital, Detroit, Michigan
Magna Cum Laude: German Board of Medicine, University of Tuebingen, Germany
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Robert Czarnecki, MD
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Volunteer Doctor: Camp Michi-MAC (a camp for children with asthma)

Specialized relief from...
- Runny/stuffy nose
- Sinus pressure
- Postnasal drainage
- Headaches
- Sneezing
- Itchy/watery eyes
- Sore throat
- Chronic cough
- Shortness of breath
- Wheezing
- Insect bites

...allergic conditions...
- Hay fever
- Allergy
- Asthma
- Respiratory allergies
- Sinus trouble
- Eczema
- Food & drug allergies
- Yeast syndrome
- Hives

...through advanced treatment.
- Allergen immunotherapy
- Avoidance counseling
- Advanced pharmaceuticals
- Food elimination diet counseling

We speak your language.
- Wir sprechen Deutsch
- Mòwimy po Polsku

Allergy & Asthma Center of Rochester

Over 40 years of proven results.

RATED AMONG AMERICA'S TOP PHYSICIANS IN ALLERGY
by Consumers Research Council of America

Dear Patient:

We appreciate your confidence in choosing our office to help you with your allergy and asthma problems.

We would appreciate you arriving promptly at the appointment time that you are scheduled for with all the online forms completely filled out. You will be asked for your insurance card and driver's license to be copied and kept in your file, so please bring them with you.

Because of the large amount of time in our schedule allotted to your appointment, we would appreciate your courtesy in giving our office at least 24-hours notice, if it is necessary to change your appointment.

Please make sure to carefully read the following instructions for preparing for your particular appointment below in order to avoid having to reschedule your appointment:

Allergy Testing (for foods and environmentals) - This appointment will take 1 1/2 to 2 hours to complete. Do not take allergy medications or decongestants 2 days (or 48 hours) prior to your appointment since they can block the allergy test results.

Patch Testing (for metals, chemicals, cosmetics) - There are three appointments total in the same week. The first appointment will last about an hour. The follow up appointments will last about 15 minutes or less. Make sure that you are not taking any steroids for at least 10 days prior to your initial appointment since they can block the patch test results. It is also important to keep your back clear of any creams or lotions since that is where the patches will be applied.

Drug Testing (for example Penicillin testing, etc.) or Challenges (with medications or foods) - These types of appointments can last from 2 ½ to 3 hours. Do not take allergy medications or decongestants 2 days (or 48 hours) prior to your appointment since they can block the results of these drug tests and challenges.

Stinging Insect Testing - This appointment will take 2 1/2 hours to complete. Do not take allergy medications or decongestants 2 days (or 48 hours) prior to your appointment since they can block the stinging insect test results.

Consult only (for an asthma check or any other medical issue you would like to address) - This appointment can last about an hour or less. No special preparation is required.

(248) 651-0606 • Fax: (248) 651-5335 • 1135 West University, #135 • Rochester, MI 48307
Visit our website at www.aaacr.com

Beaumont William Beaumont Hospital · CRITTENTON HOSPITAL IN ROCHESTER · Mercy St. Joseph's

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If you have any questions about a specific medication or any other questions related to your appointment, please call our office at 248-651-0606.

If your insurance requires a written referral to see a specialist, it is your responsibility to bring it with you at the time of the appointment (or have it faxed to our office at 248-651-5335). Because of the policies of these types of insurance companies, if we do not have this referral at the time of the appointment, you will be asked to pay in full for the visit or reschedule.

If your insurance requires you to pay a specialist copay, you will be asked to pay upon checking out at your appointment. We accept, Visa, MasterCard, American Express, Discover, Apple Pay, as well as checks and cash.

Once again, thank you for selecting our office and we look forward to meeting you. If you have any questions at all, please don't hesitate to contact us.

Sincerely,
Ulrich O. Ringwald, M.D.
Robert C. Czarnecki, M.D.

Office Hours

Monday	9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 6:00 p.m.
Tuesday	9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m.
Thursday	10:00 a.m. to 12:00 p.m. and 1:00 p.m. to 6:00 p.m.
Friday	9:00 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m.

For a map and directions to our office please click on the "Location" link on our website menu navigation.

ALLERGY AND ASTHMA CENTER OF ROCHESTER

FOR CHILDREN AND ADULTS

ULRICH O. RINGWALD, M.D. ROBERT C. CZARNECKI, M.D.

1135 W. UNIVERSITY DRIVE, SUITE 135 ROCHESTER, MICHIGAN 48307 Telephone 248/651-0606

Patient Data

PLEASE PRINT CLEARLY

Patient's Name _____ Date _____

Date of Birth _____ Age _____ Marital Status _____ Sex: M ☐ F ☐

Address _____

City _____ State _____ Zip _____ Phone # _____

Social Security # _____ Occupation _____

Employer's Name _____

Employer's Address _____

Employer's Phone # _____

Spouse's Name / Legal Guardian's Name: _____

Address, If Different _____

Home Phone# _____ Work Phone # _____

Employer's Name _____

Employer's Address _____

Who Is Financially Responsible For This Bill? _____

Their Social Security # _____ Driver's License # _____

Address, If Different _____

Home Phone # _____ Work Phone # _____

I Will Be Paying By Cash ☐ Check ☐ Credit Card ☐

Name of Person Who Referred You to Us: _____

Address _____ Phone # _____

Name of Family or Referring Physician _____

Address _____ Phone # _____

In Case of Emergency Contact _____

Relationship _____ Phone # _____

Insurance Information

Name of Primary Insurance _____ PPO ☐ HMO ☐

Address _____

_____ Phone # _____

Name of Subscriber _____ Social Security # _____

Birthdate of Subscriber _____ Relationship _____

Contract # _____ Group # _____

Name of Secondary Insurance _____ PPO ☐ HMO ☐

Address _____

_____ Phone # _____

Name of Subscriber _____ Social Security # _____

Birthdate of Subscriber _____ Relationship _____

Contract # _____ Group # _____

Medicare # _____ Is Medicare Secondary ☐ Primary? ☐

Name of Insurance Supplemental To Medicare _____

Supplemental Contract # _____ Group # _____

Medicaid # _____ If In A Medicaid Sponsor Program, Name of The

Referring Physician _____ Phone # _____

Please provide us with your insurance cards so that we may make a copy of them for your record and advise us immediately of any change in carrier or coverage. Thank you for helping us maintain accurate records!!

1. What is your main difficulty now?
   Mark an x after any of the following which bothers you.
   Mark xx if severe and xxx if extremely severe.

Coughing	Nasal Blockage	Sore Throat
Wheezing	Running Nose	Itchy Throat
Shortness of Breath	Sneezing	Headache
Chest Pain	Post Nasal Drainage	Eye Itching
Skin Itching	Itchy Nose	Tearing
Skin Rash	Nose Bleeds	Ear Blockage
Hives or Swelling	Loss of Taste or Smell	Hearing Loss
Nausea or Indigestion	Diarrhea	Colic or Cramps
Vomiting	Frequent Colds	Hoarseness
Fatigue	Nervousness	Insect Reactions

Other, Describe _____

_____

_____

2. Put the **approximate onset** of the symptoms by **month** and **year** beside each of the symptoms you have checked above.
3. Which Symptom is most bothersome? _____
4. Which of the above symptoms if any were present in prior years, but not recently? Explain

_____

_____

_____

_____

5. Is there anyone among your relatives who has or had allergy trouble, sinus disease, hayfever, migraine, asthma, chronic cough, skin allergy, eczema, hives or drug allergy?

_____

_____

6. Have you had any major illnesses? _____

_____

_____

7. List Hospitalizations, most recent first.

REASON HOSPITALIZED	DATES	REASON HOSPITALIZED	DATES
a) _____		b) _____	
c) _____		d) _____	

8. Are your symptoms worse during certain Seasons? _____ Which Seasons? _____

   List the months when you feel worse. _____
9. List the months when you feel best. _____

10. CHECK **ONE ANSWER** FOR EACH QUESTION EVEN IF YOU HAVE TO GUESS.

Are Your symptoms worse or better			
-when in air conditioning.....	Worse ☐	Better ☐	No Change ☐
-when the weather is sunny	Worse ☐	Better ☐	No Change ☐
when the weather is cloudy or humid.....	Worse ☐	Better ☐	No Change ☐

-during quick weather changes	Worse ☐	Better ☐	No Change ☐
-when it rains	Worse ☐	Better ☐	No Change ☐
-when you are outdoors	Worse ☐	Better ☐	No Change ☐
-when you are indoors	Worse ☐	Better ☐	No Change ☐
-in the morning before arising	Worse ☐	Better ☐	No Change ☐
-in the morning after arising	Worse ☐	Better ☐	No Change ☐
-at night	Worse ☐	Better ☐	No Change ☐
-on exposure to house dust	Worse ☐	Better ☐	No Change ☐
-when sleeping on feather pillows	Worse ☐	Better ☐	No Change ☐
-on exposure to freshly cut grass	Worse ☐	Better ☐	No Change ☐
-in fields or in tall weeds	Worse ☐	Better ☐	No Change ☐
-when camping	Worse ☐	Better ☐	No Change ☐
-on exposure to barns or hay or raking leaves	Worse ☐	Better ☐	No Change ☐
-after ingestion of beer, wine, or alcoholic beverages	Worse ☐	Better ☐	No Change ☐
-after exposure to animals (which animals_____)	Worse ☐	Better ☐	No Change ☐
-when you are showering	Worse ☐	Better ☐	No Change ☐
-when swimming or exercising	Worse ☐	Better ☐	No Change ☐
-on exposure to drafts, heat or cold	Worse ☐	Better ☐	No Change ☐
-on exposure to tobacco smoke	Worse ☐	Better ☐	No Change ☐

11. List foods you suspect: _____

_____

List Symptoms these foods cause _____

_____

12. List all drugs which cause symptoms.

DRUGS SYMPTOMS

_____

_____

_____

13. How are you feeling away from home on vacation? Worse ☐ Better ☐ No Change ☐

Location _____

14. Have you ever had allergy skin tests and/or treatment?_____By whom? _____

Date: From_____To_____(Date of Last Shot)

Were you: ☐ Better_____(Percent) ☐ Worse ☐ No Change

Did you have reactions? Local ☐ General ☐ Immediate ☐ After 12 Hours ☐

15. How much time have you missed from work or school in the past twelve months?_____Days.

16. What did your doctor tell you that you had?_____

17. What did your doctor and you expect us to do first? _____

_____

18. Since when have you lived in your present home? Date_____

How did you feel in your previous home Worse ☐ Better ☐ No Change ☐

19. Check the features listed below which most closely describe your house.

a) Brick ☐ Frame ☐ Asbestos Siding ☐ Aluminum Siding ☐

b) Dry Basement ☐ Damp Basement ☐ Musty Basement ☐

c) Dehumidifier ☐ Humidifier ☐ None ☐

d) Gas Heat ☐ Oil Heat ☐ Coal Heat ☐ Electric Heat ☐

e) Forced Heat ☐ Gravity ☐ Baseboard Hot Water ☐

f) Centeral Air Conditioning ☐ Window Air Conditioning ☐ None ☐

g) Electronic Air Cleaner ☐ None ☐

h) Dog ☐ Dogs ☐ Cat ☐ Cats ☐ Guinea Pig-s ☐ Rabbits ☐ Rodents ☐ None ☐

i) Indoor Pets ☐ Outdoor Pets ☐ How long have you had them? _____

j) Describe Patient's Bedroom: _____

Pillow: Feather ☐ Foam Rubber ☐ Dacron ☐ Mattress: Cotton ☐ Foam Rubber ☐

k) Who smokes in the house? Family ☐ Patient ☐ Visitor ☐ None ☐

l) Have you ever smoked? _____ How Much? _____ packs a day. Age started _____ Age Stopped _____

m) Are you worse in some rooms? Which Room? _____

20. What type of work do you do? (Describe and give date) _____

_____

21. Are your symptoms affected by your job? _____

22. How do you feel at work compared with home? Worse ☐ Better ☐ No Change ☐

23. How do you feel on weekends? Worse ☐ Better ☐ No Change ☐

24. What medication and/or other programs are you on at present? _____

_____

25. What medication have you tried in the past? _____

_____

26. Has any lab work been done recently? Blood Test?

Urine Test?

X-Ray Study?

27. Is your Tuberculin Skin Test Positive ☐ Negative ☐ Don't Know ☐ Date ☐

28. Do you comtemplate changing your home in the future?

29. Any questions? _____

_____

_____

_____

If you have a question about our participation in your plan, please contact our office staff. All patients are responsible for keeping their insurance information current. On subsequent visits, it is the patient's responsibility to advise our office of any insurance change, **before service is rendered**. The new insurance card and referral, if necessary, must be presented when signing in. Patients will be held financially responsible for all services for which correct insurance information was not provided or required authorization was not obtained.

HMO/PPO/COMMERCIAL/MEDICAID INSURANCE PATIENTS

If you are enrolled in an HMO, PPO, Commercial, or Medicaid plan in which we participate, we will direct bill your insurance company. HMO, PPO, Commercial insurance patients are responsible for all copays and deductibles indicated by your insurance company. We ask that these be paid at the time of service, as much as is practical. In some cases it may be necessary to have the claim processed first before your responsible portion can be determined. Please complete the following authorization if you are enrolled in one of these plans (Medicaid patients should also complete the information below so that you can authorize us to bill your insurance):

I _____ am a participant in _____
(patient's name) **(name of your health plan)**

health plan in which this office is a participating provider. I authorize them to release any medical information that my insurance company requests and authorize all payments be made directly to the Allergy and Asthma Center of Rochester. I will be responsible for payment of all deductibles and copays charged by my insurance company. I understand that if my insurance company requires prior referral authorization from my primary physician, *I am responsible for obtaining that authorization. If there is not a valid authorization issued for any date of service that I am treated by the doctors at this office, I will be fully responsible for all charges related to that date of service.*

Patient Signature: _____ Date: _____
(parent or legal guardian sign if patient is a minor)

MEDICARE PATIENTS

We are a participating provider in the Medicare plan and will bill Medicare directly for all covered services. The patient will be responsible for all copays and deductibles and non-covered services such as B12 injections, immunizations, cortisone injections, etc., once the claim has been processed by Medicare. If you are a Medicare patient, please complete the following:

I _____ request payment of authorized Medicare benefits directly to the Allergy and Asthma Center of Rochester. I authorize any holder of medical information regarding me to release to the HCFA or its agents any information needed to determine benefits.

Patient Signature: _____Date:_____

Is Medicare primary?_____Y_____N

Are you presently still working?_____Y_____N

If yes, are you covered by an insurance plan at work? Name of plan _____

If no, and Medicare is primary, what is the name of your secondary plan?_____

Patient Signature:_____Date:_____

>>>>>>>>>>>>>>>>>>ALL PATIENTS SIGN AND DATE BELOW (IF THE PATIENT IS A MINOR, A PARENT OR LEGAL GUARDIAN MUST SIGN AND DATE THE FORM BELOW)<<<<<<<<<<<<<<<<

I have read the financial policy and understand and agree by my signature to abide by the financial policy. **THE ADULT OR LEGAL GUARDIAN ACCOMPANYING A MINOR TO THE APPOINTMENT WILL BE HELD RESPONSIBLE FOR THE PAYMENT OF THE CHARGES ON THE DATE OF SERVICE, REGARDLESS OF WHO IS LEGALLY RESPONSIBLE FOR THE CHILD'S MEDICAL CHARGES.**

Signature of patient or parent (legal guardian): _____Date: _____

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Patient Consent and Acknowledgement

I understand that, under the Health Insurance and Portability & Accounting Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and read your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that Allergy and Asthma Center of Rochester, Michigan has the right to *change* its Notice of Privacy Practices from time to time and that I may contact Allergy and Asthma Center of Rochester, Michigan at any time at the address below to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

(248) 651-0606 • Fax: (248) 651-5335 • 1135 West University, #135 • Rochester, MI 48307
Visit our website at www.aaacr.com

Dear New Patient, we have an Electronic Health Record (EHR) Computer System. Please help us by completing the information below.

Please Print Your First and Last Name _____

Chart Number [leave this blank] _____

Name of Your Pharmacy _____

Pharmacy Address _____

Pharmacy Telephone _____

Your E-mail Address _____

Go to the Next Page and Fill Out the U.S. Government Questions

[Do Not Fill Out Form Below - Doctor Use Only]

Bronchial Asthma		Rhinitis	Urticaria	Food Allergy	Stinging Insects	GI	Derm	Drugs
Stable	Exacerbation	Pollen (P)	ANA	Milk	Bee (B)	GERD LERD	Contact Dermatitis	Penicillin
Mild	Moderate	Mite/Molds (M)	Angioedema	Peanut	Yellow Jacket (W)	IBS With W/O	CD Cosmetics CD Drug	Sulfa
Severe	Exercise Induced	Animals (D)	HANE	Tree Nut	(YH) Hornet (WH)	Colitis Crohn's	CD Dye	AB Non AB
Intermittent	Persistent	Vasomotor	Allergic	Egg	Wasp (W)	Celiac	CD Metals CD Eyelids	Drugs/Bio
VCD	With Exacerbation	Chronic	Dermographism	Seafood	Insect	Allergic Enteritis	CD Plants	X-Ray Dye
Cough Habit	COPD Respiratory Infection	Foods Laryngitis	Idiopathic Other Chronic	Fish Vegetables	Nasal Polyps NSD	Diarrhea Colic	Irritant Dermatitis	Anesthetics Narcotics
Wheezing	Tobacco H U	Cold	Vibratory	Other Food Adverse Food	Cerumen	Projectile Vomiting	Latex Allergy	Vaccine Serum
A Bronchitis C Emphysema	Pneumonia URI	Pharyngitis Tonsillitis	Pruritus	Allergy Testing FH Allergy	Polyp VC	Candidiasis Stomach Pain	Eczema AD Hand Eczema	Adverse Drug
CVBA Dyspnea	Fibromyalgia Migraine	Frontal A Sinusitis C Max	Vertigo Dizziness	Conjunctivitis L R B Dry Eye Synd.	Fatigue	Herpes Herpes Zoster	Thrush Rosacea	Seb. Derm Impetigo
Influenza	Tension Headache Sinus	OE AOM L R B SOM ETD	Flu		Tinea Versicolor Tinea Cruris	Vasculitis	Psoriasis	Scabies Pityriasis

Acute Chronic A1 A2 V1 V2 Left Right Bilateral Upper Lower A D S Unspecified Status

----------[New Patient, Please Complete this Form Below]----------

The U.S. Government wants physician practices to collect the following information on all patients. Please answer the following questions below.

1. Are you a smoker? (Check a box) ☐ Yes No ☐

2. Are you a past smoker? (Check a box) ☐ Yes No ☐

3. What is your Ethnicity? (Check a box below)

☐ Prefer not to answer ☐ Not Hispanic or Latino ☐ Hispanic or Latino _____
(please specify)

4. What is your Race? (Check a box below)

☐ Prefer not to answer ☐ White ☐ Black or African American ☐ Asian ☐ Other _____
(please specify)

5. What is your Preferred Language? (Check a box below)

☐ English ☐ Spanish ☐ Other _____
(please specify)

6. What is your contact preference? (Check one box and fill out contact info below if there is a blank line.)

☐ Home Address ☐ Home Phone _____ ☐ Work Phone _____

☐ Mobile Phone _____ ☐ E-mail _____

7. Name of Contact for Patient _____ Relationship to Patient _____

Thank you for completing this information. Please bring this sheet and the rest of the required paperwork to your appointment.