

# Midwest Ear, Nose & Throat Consultants, Ltd.

You are responsible for notifying your insurance company before your scheduled test. Failure to do so can result in nonpayment of insurance benefits. Allergy testing and treatment will be billed by the doctor ordering the testing. Patients with insurance coverage through an **HMO** or **POS** (Point of Service) **are required to contact their primary care physician** instead of their insurance carrier to obtain the mandatory referral.

When you contact your insurance company, you must ask the following:

1. Is precertification necessary?
2. Is allergy testing a covered benefit? (See next page for specific information.)
3. What portion of the total cost of allergy testing will be covered?

**HMO/POS** members must call their assigned Primary Care Physician (PCP) or the full service unit. The PCP will determine if the test being performed is a covered expense and if the physician is an in-plan provider. **PLEASE BRING YOUR REFERRAL prior to or at the time of testing.**

All patients will be required to pay your insurance co-pay at the time of testing.

I understand the above policies and accept responsibility for the balance not covered by my insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

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## CONSENT FOR TESTING

Allergy testing consists of multiple injections beneath of the skin of the upper arms similar to mosquito bites, which become red and swollen when positive. The nurse then measures the diameter. The risk of this type of procedure is minimal, but in rare instances adverse reactions (side effects) can include but are not limited to swelling, skin rashes or difficulty breathing. Our office is equipped to handle these problems should they arise.

I authorize the staff at Midwest Ear, Nose & Throat Consultants, Ltd. to perform Serial Endpoint Testing (skin testing for allergies) on my child, or myself and I understand the risks involved.

\_\_\_\_\_  
Patient (Parent or Guardian) signature, if minor

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**If you have any questions, please contact us at (630) 668- 2180, ext 7619 if being seen in the Winfield (CDH) office or ext. 7725 for the Geneva office. If being seen in the Naperville office, please call (630) 420-2323, ext. 7678.**

Allergy-Testing Consent



**PATIENT PREPARATION FOR ALLERGY TESTING**

\*\*\*\*\* Please advise the nurse if you have asthma or are currently pregnant \*\*\*\*\*

\*\*\*\*\* Please advise the nurse if you are currently taking Beta-blocker medication for high blood pressure or migraines \*\*\*\*\*

\*\*\*\*\* DO NOT TAKE anti-histamines for 1 week before allergy testing \*\*\*\*\*

Keep in mind that many over-the-counter medications for allergy, cold, and flu contain anti-histamines. Read these labels carefully!

Instructions for Patients:

- Testing will consist of small injections under the skin (they feel like mild skin pricks).
- Wear a short sleeve or sleeveless machine-washable shirt on the day of testing.
- Eat normal meals and push fluids the way before and the day of testing.
- Testing will take approximately 1 ½ - 2 hours.
- Please do not bring (other) young children to this appointment.
- Check in at the front desk of ENT clinic to fill out any necessary paperwork.
- Please call to cancel if you have major surgery within the past month or any illness within the week before testing.
  - Please call ASAP to reschedule for ANY reason; appointment times are precious! WE REQUIRE A 24-HOUR CANCELLATION NOTICE. If a 24-hour notice is not given, a charge of \$50 will be billed to your account.

Instructions for Pediatric Patients only:

- A topical anesthetic may be used to decrease sensation in the child's arms
- Pharmacy phone number: \_\_\_\_\_ Called: Y N
- On the day of the test, ONE HOUR before testing, generously apply the cream to BOTH of the child's upper arms, between shoulders and elbow.
- Wrap the arms in plastic wrap and keep it in place until the nurse removes it.

APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

Follow-up appointment with MD: Date \_\_\_\_\_ Time \_\_\_\_\_

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## ALLERGY HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Family Physician's Name & Address: \_\_\_\_\_

Family Physician's Phone Number: \_\_\_\_\_

Would you like your test results sent to your physician?  YES  NO

**General:** *Describe* your allergy symptoms and when they began:

\_\_\_\_\_

*Please list* any treatments or medications you have tried and how effective they were: \_\_\_\_\_

\_\_\_\_\_

*Please list* any medications you are currently taking: (include over-the-counter medication, aspirin, vitamins, herbals, etc.) \_\_\_\_\_

\_\_\_\_\_

*Please list* any medication allergies you have: \_\_\_\_\_

\_\_\_\_\_

*Please list* any hobbies, travel or recreational activities: \_\_\_\_\_

\_\_\_\_\_

Do you live in a:  House  Apartment  Townhouse  Condo

**In the following sections, please place a checkmark if you have experienced any of the following:**

**The Ears**  Ringing  Drainage  Dizziness  Pain/Pressure  
 Temporary or permanent hearing loss  Frequent infections

***Describe any previous ear surgeries:*** \_\_\_\_\_

\_\_\_\_\_

**The Eyes** Do you regularly experience:  Watering  Itching  Glaucoma  
 Red or swollen eyelids  Puffiness around the eyes  Night blindness

When and how often? \_\_\_\_\_

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**The Nose** Do you regularly experience:  Itchy nose  Sneezing  Runny nose  
 Stuffiness  Green or yellow nasal discharge  Postnasal drip  Poor sense of smell **How often?** \_\_\_\_\_

Do you have nasal polyps?  Yes  No

**The Throat** Do you regularly experience:  Swollen or sore tongue  Hoarse voice  
 Feeling that you have to clear your throat frequently  Cold sores  Bad breath  
 Swollen lips or glands  Itchy mouth or tongue  Frequent infections or sore throat  
**How often?** \_\_\_\_\_

**The Chest/Asthma**  Wheezing  Shortness of breath with exertion  chronic cough  
 Shortness of breath at rest  Frequent bronchitis  Pneumonia  
 Wheezing or shortness of breath that has awakened you from sleep  
**How often?** \_\_\_\_\_

**Have you** been diagnosed with asthma?  YES  NO  
**Has a** physician prescribed an inhaler for you?  YES  NO  
**List** any activities or times of the year which seem to trigger your symptoms \_\_\_\_\_

**Gastrointestinal** Do you regularly experience:  Acid reflux, acid indigestion or heartburn  Indigestion or bloating after meals  
 Belching  Constipation or diarrhea **How often?** \_\_\_\_\_  
**List** any foods that disagree with you \_\_\_\_\_ **Have you** had colitis, ulcers or gallbladder problems? **Describe** \_\_\_\_\_

**Head and Neck** Do you regularly experience:  Headaches (sinus, migraine or other)  
**List** any medications you take for headaches \_\_\_\_\_

**Do you** feel lightheaded or "spacey" at times?  YES  NO **Are you** drowsy after meals?  YES  
 NO **Are you** tired all the time?  YES  NO

**(Women only)** **List** any hormone medications you are taking : \_\_\_\_\_

**Are you** currently pregnant?  YES  NO  
**Do you** get frequent yeast infections?  YES  NO

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**Skin, Joints and Muscles** Do you regularly experience:  Eczema  Psoriasis  
 Hives  Rash  Arthritis  Cold feet  Swollen joints  Brittle nails  
 Acne  Fungal infection of skin or nails

**Childhood History** Did you experience any of the following as a child:  
 Eczema  Feeding problems  Hyperactivity  Frequent ear or throat infections  
 Frequent or chronic cough  Stomach aches  Vomiting  Diarrhea or constipation

**Family History** Have your parents, brothers or sisters had any of the following:  
 Asthma  Allergies/Hay fever  Sinus problems  Frequent headaches  
 Other \_\_\_\_\_

**Dust and Mold** Do any of the following seem to make your symptoms worse?  
 Being in your home  Being at work  Being away from home  Dusting  
 Mowing the Lawn  Raking leaves  Being in a basement  Damp weather  
 Having beer, wine or cheese

**Feathers and Animals** Does contact with any of the following seem to worsen your symptoms?  Cat  
 Dog  Horse  Bird  Rabbit  Guinea pig  
 Feather pillows or down comforters  Other \_\_\_\_\_  
**List** any pets you have or regularly visit: \_\_\_\_\_

**Chemicals/Pollutants/Miscellaneous** Do any of the following make your allergy symptoms worse:  Vehicle exhaust  City air pollution  Paint fumes  Smoke  
 Reading a newspaper  Exposure to powder, perfumes or cosmetics  
 Other \_\_\_\_\_  
**Do you** have a  Gas stove  Gas furnace  Oil or wood burning furnace  
 Other \_\_\_\_\_

**Describe what bothers you the most and when** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of nurse performing testing: \_\_\_\_\_ Date \_\_\_\_\_