



SONGHUI MA, MD

Empire Allergy and Asthma

154 West 14th Street, 4th Floor
 New York, NY 10011
 Ph: 212-342-7410

Date:

Patient's Name:		Date of Birth:	
Street Address:		Age:	
City/State/Zip:		Home Phone:	
Social Security Number:		Work Phone:	
Occupation:		Cell Phone:	
Patient's Employer/Address:		Email:	
Referring Physician/Address:			
Additional Physician Reports To:			
Emergency Contact:			
Sex:	Male Female	Marital Status:	Married Single Divorced Widowed

PRIMARY INSURANCE (copy of insurance card is required)

Name of Insurance Company:			
Address:			
ID or Policy Number:		Group #:	
Effective Date of Insurance:			
Who is Subscriber: (check one)	Self	Spouse	Parent Other

If Subscriber is other than Self - Complete the following:

Subscriber's Name:			
Sex:	Male	Female	
Address:			
Date of Birth:			
Social Security Number:			

SECONDARY INSURANCE (copy of insurance card is required)

Name of Insurance Company:			
Address:			
ID or Policy Number:		Group #:	
Effective Date of Insurance:			
Who is Subscriber: (check one)	Self	Spouse	Parent Other

If Subscriber is other than Self - Complete the following:

Subscriber's Name:			
Sex:	Male	Female	
Address:			
Date of Birth:			
Social Security Number:			

Date:

Patient's Name:

Date of Birth:

AUTHORIZATION INFORMATION (Assignment of Benefits)

I hereby assign to Songhui Ma, M.D. any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arraignment, payment to the practice will be made by any insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except where prohibited by contract). I also understand that in the event that services rendered are not covered under by "insurance," I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the assignment) at this time.

Signature:

Date:

FOR RELEASE OF INFORMATION

I authorize the release of any medical information or other information as is necessary to process this claim based upon the HIPAA Notice of Privacy Practices, information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature:

Date:



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Date: _____

Patient's Name: _____

Date of Birth: _____

Major reason for allergy consultation: _____

DO YOU HAVE ANY NASAL, SINUS, EYE OR EAR SYMPTOMS:

Yes No

If yes, please check each box that applies to you:

Nasal Congestion	Itchy Nose	Headache	Throat Clearing
Runny Nose	Itchy Eyes	Sinus Pressure	Bad Breath
Sneezing	Watery Eyes	Snoring	Decreased Sense of Taste/Smell
Post Nasal Drip	Ear Problems	Sore Throat	Hoarseness

When do you have symptoms:

Spring	Summer	Fall	Winter
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What makes your symptoms worse:

Dust	Mold	Foods	Change of Seasons
Trees	Dogs	Strong Odors	Alcohol
Grass	Cats	Perfume	Stress
Weeds	Cigarettes	Cold Weather	Strong Emotions
Other: _____			

Do you have frequent, prolonged or unusually severe infections:

Upper respiratory	Sinus	Ear
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When did your symptoms first start: _____

Do you wear contact lenses:

Yes No

DO YOU HAVE ANY BREATHING PROBLEMS:

Yes No

If yes, please check each box that is applicable to you:

Cough	Wheeze	Shortness of breath	Chest tightness
Throat tightness	Worse at night	Worse during day	Worse with exercise

When do you have symptoms:

Spring	Summer	Fall	Winter
--------	--------	------	--------

What makes your symptoms worse:

Dust	Mold	Foods	Change of Seasons
Trees	Dogs	Strong Odors	Alcohol
Grass	Cats	Perfume	Stress
Weeds	Cigarettes	Cold Weather	Strong Emotions
Other: _____			

Do you have frequent, prolonged or unusually severe infections:

Bronchitis Pneumonia

When did your symptoms first start: _____



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DO YOU HAVE ANY SKIN PROBLEMS: Yes No

If yes, please check each box that applies to you:

Eczema Hives Swelling Other _____

What makes your symptoms worse: _____

When did your symptoms first start: _____

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING:

Medications Foods Bee/Insect Stings Latex

HAVE YOU EVER BEEN TESTED FOR ALLERGIES:

Yes No *if yes, when* _____

HAVE YOU EVER BEEN TREATED WITH ALLERGY SHOTS:

Yes No *if yes, when* _____



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Do you have any medical problems?	
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Please list all your medications and dose:	
--	--

Does anyone in your family have allergies or asthma:	
--	--

Are there any other medical problems that run in your family:	
---	--

Are you pregnant or planning to become pregnant:	
--	--

What is your occupation:

What kind of building do you live in:

Pre-War Apartment Post-War Apartment Townhouse House

What type of heating do you have:

Radiator Forced Hot Air Baseboard Fireplace

What type of Airconditioning do you have:

None Window Central

What type of floors do you have:

Wood Area Rug Wall-to-Wall Carpeting Other _____

Do you have any pets:

Cat Dog Other _____

Do you have an air filter:

None Room Unit Central HEPA

Do you use allergen/dust mite covers:

None Pillow Mattress

Do you have any problems with:

Mold Dampness Leaks Flooding Mustiness

Have you noticed any of the following at home:

Roaches Mice Rats



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Date:

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Do you smoke cigarettes:

Yes No Quit

If Yes/Quit:

How Much: _____ How Long: _____

Do anyone in your household smoke:

Yes No

Do you have any of the following problems:

- | | | | | |
|----------------------|--------------------------|-------------------------|----------------------|-------------------------|
| Fever | Sweats | Weight Loss/Gain | Poor Energy | Insomnia |
| Headache | Vision Problems | Glaucoma/Cataracts | Hearing Loss | Tinnitus |
| Vertigo | Dizziness | Chest Pain | Palpitations | Coronary Artery Disease |
| Angina | Heartburn | Gastroesophageal Reflux | Peptic Ulcer Disease | Nausea |
| Abdominal Pain | Vomiting | Diarrhea | Constipation | Liver Problems |
| Kidney Problems | Over/Underactive Thyroid | Diabetes | Swollen Lymph Nodes | Anemia |
| Bruising/Bleeding | Muscle Pain | Joint Pain | Arthritis | Incontinence |
| Difficulty Urinating | Prostate Problems | Menstrual Problems | Weakness | Numbness |
| Seizures | Depression | Anxiety | | |