

Joann Blessing-Moore, M.D.

*Asthma/ Allergies/ Immunology- Children and Adults, Pediatric Lung Disease
Board Certified: Allergy Immunology; Pediatric Pulmonology*

723 Emerson St, Palo Alto, CA 94301
(650)688-8480 FAX; (650) 688-8483
101 S. San Mateo Dr. Ste: 311 San Mateo, CA 94401
(650) 696-8236 FAX: (650) 696-8229

Welcome to our office!

Your appointment is scheduled for _____ at _____ am/pm,
in our Palo Alto / San Mateo office.

Our medical staff includes Dr. Blessing-Moore and specially trained allergy nurses. As you may know we divided our time between Palo Alto and San Mateo. You may be seen at either office, but your medical record will be kept at one location. We do all procedures at both offices, including medical history, evaluation, pulmonary function testing, special allergy testing and allergy shot treatment.

At the time of your visit it is essential that you bring your insurance card with you, as well as a photo ID. Also if it is required of your medical insurance, you must have a referral from your primary care physician. If you have a co-payment please be prepared to pay it at the time of service WE DO NOT BILL FOR CO-PAYMENTS. If you have any questions about your referrals, coverage, co-payments, etc Please call your insurance company before coming in.

Your new patient visit will be approximately 2 hours with a complete evaluation, including history, physical, pulmonary function testing, tympanometry, and treatment plan. Allergy testing will be scheduled for your next visit. Please check with your insurance company concerning authorization and coverage for a skin test and allergy shots. Remember, your insurance coverage is a contract between you and the insurance company and we have no say on what is covered.

Please provide copies of your medical records from prior visits from other physicians for pulmonary and allergy evaluations. These records should include x-rays, lab-work, pulmonary function tests, skin test and physician's summaries.

All patients must have a primary care physician. Our after hour phone messages will instruct you on what to do if you have to reach the doctor after office hours. If you are in need of emergency care go to the nearest emergency room.

Please fill out the enclosed forms and bring them with you at the time of you first visit. Remember to bring you insurance card and referral. We look forward to meeting you.

Joann Blessing-Moore, M.D.

Directions to our offices

SAN MATEO OFFICE:

FROM 280:

TAKE 280 TO HWY 92 EAST
EXIT EL CAMINO REAL NORTH
GO STRAIGHT TO SECOND AVE THEN TURN RIGHT
GO STRAIGHT TO ELLSWORTH AVE TURN LEFT
OUR BUILDING IS THE ONE JUST AFTER FIRE STATION
GO INTO THE UNDERGROUND PARKING GARAGE
TAKE THE ELEVATOR TO THE 3RD FLOOR

FROM 101:

TAKE 101 TO 3RD AVE GOING WEST
GO STRAIGHT TO ELLSWORTH AVE TURN RIGHT
OUR BUILDING IS THE ONE JUST AFTER THE FIRE STATION
GO INTO THE UNDERGROUND PARKING GARAGE
TAKE THE ELEVATOR TO THE 3RD FLOOR

PALO ALTO OFFICE:

FROM 280:

TAKE 280 TO SAN HILL ROAD GOING EAST
GO DOWN SAN HILL ROAD TOWARDS STANFORD HOSPITAL
TURN RIGHT ONTO EL CAMINO
STAY TO THE RIGHT TO EXIT ONTO UNIVERSITY
TURN LEFT ONTO UNIVERSITY
TURN RIGHT ONTO EMERSON ST
PARKING IS STREET PARKING OR THERE ARE 4 SPACES LABELED FOR DR
BLESSING-MOORE PATIENTS

FROM 101:

TAKE 101 TO UNIVERSITY AVE GOING WEST
TURN LEFT ONTO EMERSON ST
PARKING IS STREET PARKING OR THERE ARE 4 SPACES LABELED FOR DR
BLESSING-MOORE PATIENTS

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DATE: _____

OFFICE FOR PRIMARY VISIT: PALO ALTO SAN MATEO (CIRCLE ONE)

PERSONAL INFORMATION

PATIENT'S NAME: _____ DOB: _____ SEX: M / F
ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____
HOME PHONE: _____ SSN: _____ DL NO: _____
EMPLOYER: _____ WORK PHONE: _____
OCCUPATION: _____ MARITAL STATUS: _____

NAME OF SPOUSE SIGNIFICANT OTHER: _____
DOB: _____ SSN: _____
EMPLOYER: _____ WORK PHONE: _____
OCCUPATION: _____

PRIMARY CARE PHYSICIAN

NAME: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
REFERRED BY: _____
OTHER PHYSICIANS INVOLVED IN CARE: _____

ADDRESSES: _____

PHONE NO: _____

INSURANCE INFORMATION

HMO ___ PPO ___ MEDICARE ___ MEDICAL ___ PRIVATE ___ (PLEASE CHECK ONE)
PRIMARY CARRIER: _____ ID NO: _____
SUBSCRIBER: _____ GROUP NO: _____
SECONDARY CARRIER: _____ IDNO: _____
SUBSCRIBER: _____ GROUP NO: _____

*****WE NEED A CURRENT COPY OF YOUR CARD(S) AND A SIGNED CLAIM FORM (IF APPLICABLE) *****

EMERGENCY CONTACT PERSON: _____
NAME: _____ RELATIONSHIP: _____
PHONE: _____

FINANCIAL ARRANGEMENTS & INSURANCE

We are committed to providing you with the best possible care. If you are covered by medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assurance and your understanding of our financial policy.

We are contracted with many insurance companies. Some contracts are directly with your plan. Please contact our business office as they can best answer your questions. In order to be able to file your claims we must have a copy of your insurance card, and if applicable a signed claim form. When there is a change in your insurance plan or coverage please notify us as soon as possible. Without this information we will be unable to submit your claim to your insurance for payments.

YOU MUST REALIZE, HOWEVER, THAT:

1. Dr. Blessing Moore is a specialist and as such she is not in a position to provide primary medical care to her patients. Therefore, it is required that all patients be under the current care of a primary care physician (PCP). If you do not have a PCP you will need to contact your insurance company for a current listing of the plan physicians.
2. Your insurance coverage is a contract between you /you and your employer, and the insurance company. We are not a party to that contract.
3. As Dr. Blessing-Moore is a specialist, some insurance companies require that prior to any visits you must obtain an authorization or referral from your primary care physician. If this is not done by the time of your appointment you will be asked to reschedule your appointment and contact your PCP, or pay for the service at the time you are seen. Any payments made at the time of the service will be promptly refunded upon receipt of payment by insurance company. Please note that most insurance companies will not cover the cost of services not listed in the authorization or referral. Skin test and allergy shots usually require a prior authorization as well. Any services which are not contracted and are denied by your insurance company are your responsibility.
4. Co-payments if required by your plan are due at the time of each visit. Please come prepared to pay the co-pay amount as determined by your insurance plan (most co-pays are listed on your insurance card). Most insurance companies require that this amount be paid at the time of service in order to validate the contract. Failure to do so could possibly reduce your benefits.
5. No matter what type of plan you have (HMO, PPO, Commercial, or indemnity) it is to your advantage as well as your responsibility to know and understand your medical insurance coverage. Not all services are covered benefits in all contracts. You will need to contact your insurance company to find out what benefits are covered under your plan, and what the reimbursements rates for the benefits are.
6. Returned check fee is \$25.00 per item, payable in cash immediately upon notification.
7. Interest will accrue at the rate of 1.5% monthly (18% annual) on all patient balances over 90 days.
8. We request that you notify us at least 48 hours in advance if you will be unable to keep your appointment. We reserve the right to charge for any appointment which is not canceled with proper notice. Our fee for a no show is \$50.00
9. We must emphasize that as medical care provider our relationship is with you not your insurance company. Therefore, all cost for services provided remain the responsibility of the patient/guarantor from the date the service is rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise we encourage you to contact us promptly for assistance in management of your account.

ASSIGNMENT AND RELEASE

I hereby assign all medical and our/or surgical benefits, if any, otherwise payable to me for services rendered directly to Dr Blessing-Moore. I have read the above financial agreement and insurance statement and I fully understand that I am responsible for all charges whether or not paid by my insurance. I hereby authorize Dr. Blessing-Moore to release all information necessary to secure the payments of the benefits from my insurance carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature of Insured

Date

PLEASE ANSWER THE FOLLOWING QUESTIONS AS BEST AS YOU CAN

PATIENTS NAME: _____ DOB: _____
REASON FOR THE VISIT TODAY: _____

WHEN DID SYMPTOMS START: _____ WHAT SEASON IS THE WORST: _____
DO YOU HAVE ANY DRUG ALLERGIES? Y / N _____
DO YOU HAVE PROBLEMS EXERCISING? Y / N _____
DO YOU HAVE PROBLEMS SLEEPING AT NIGHT? Y / N _____

(PLEASE CHECK THE SYMPTOMS YOU FIND TROUBLESOME)

LUNGS: WHEEZING ___ ASTHMA ___ SHORTNESS OF BREATH ___ CHEST TIGHTNESS ___
COUGH ___ PHLEGM ___ COUGHING UP BLOOD ___ PNEUMONIA ___

SKIN: HIVES ___ RASH ___ ECZEMA ___ DRYNESS ___ ITCHING ___ INFECTIONS ___ PSORIASIS ___

UPPER RESPIRATORY: SINUS PAIN ___ INFECTIONS ___ HEARING LOSS ___ HEADACHE ___
SNORING ___ NOSEBLEEDS ___ ITCHY/WATERY EYES ___ LOSS OF SMELL/ TASTE ___

GI: WEIGHT PROBLEM ___ LOSS OF APPETITE ___ NAUSEA ___ VOMITTING ___ DIARRHEA ___
STOMACH ACHES ___

GU: MENSES PROBLEMS ___ VAGINITIS ___ FREQUENT URINATION ___

CARDIOVASCULAR: ARRHYTHMIA ___ HEART ATTACK ___ PACEMAKER ___
BYPASS ___ ANGINA ___ HIGH BLOOD PRESSURE ___

OTHERS: SLEEP PROBLEMS ___ EMOTIONAL ___ MUSCLE PAIN ___ SLEEPAPNEA ___

OTHER NOT LIST ABOVE: _____

HAVE YOU HAD ANY PREVIOUS ALLERGY WORK-UP BY ANOTHER ALLERGIST? Y / N
NAME: _____ WHERE? _____ WHEN? _____
SKIN TEST RESULTS: _____ ALLERGY SHOTS? Y / N (LENGTH) _____
HAVE YOU EVER BEEN HOSPITALIZED? Y / N DATE(s) _____ REASONS: _____

HAVE YOU EVER HAD SURGERY? Y / N DATE(s) _____
REASON: _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION OR ANY ACTIVITY THAT WOULD CAUSE
YOU TO WORRY ABOUT HIV? Y / N _____ HAVE YOU BEEN TESTED FOR HIV? Y / N
RESULT: _____

IMMUNIZATIONS: PLEASE FILL IN DATES FOR ALL IMMUNIZATIONS
DPT ___ TETANUS ___ MMR ___ H1N1 ___ INFLUENZA ___ HEPATITIS A ___ HEPATITIS B ___
HEP A ___ PNEUMOVAX ___ VARICELA ___
WHEN WAS YOUR LAST TB TEST? _____
RESULTS: _____
OTHER IMMUNIZATIONS: _____

FAMILY HISTORY INDICATES REALTIVE WITH THESE PROVBLEMS-(M) MOM (D) DAD (S) SISTER...

ASTHMA ___ ECZEMA ___ FOOD ALLERGY ___ SINUS ___ DURG ALLERGY ___ INSECT ALLERGY ___ HEARING LOSS ___ HIVES ___ PSORIASIS ___ FREQUENT INFECTION ___ IMMUNE DEFICENCY ___ CHRONIC BRONCHITIS ___ CHRONIC LUNG PROBLEMS ___ EMPHYSEMA ___ CYSTIC FIBROSIS ___ DIABETES ___ CANCER ___ HEART DISEASE ___ STROKE ___ HIGH BLOOD PRESSURE ___ MIGRANES ___ ARTHRITIS ___ LUPUS ___ ULCER ___

PAST MEDICAL HISTORY (PLESE CHECK ALL THAT APPLY)

INFANT: ASTHMA ___ PREMATURE ___ WEIGHT PROBLEM ___ BREST/FORMULA FED ___ ECZEMA ___
CHILD: ASTHMA ___ HIVES ___ BRONCHIOLITITS ___
EAR INFECTIONS ___ PNEUMONIA/CROUP ___ CHRONIC COUGH ___
ADOLECENT: ASTHMA ___ EAR/EYE PROBLEM ___ HAY FEVER ___ SINUS
HEADACHES ___ HIVES ___ DERMATITIS ___ HEPATITIS ___ MONO ___
ADULT: ASTHMA ___ DIABETES ___ TUBERCULOSIS ___ HEART DISEASE ___ HIGH BLOOD PRESSURE ___ ARTHRITS ___ HIV/AIDS ___ HEPATITIS ___

PLEASE CHECK ANY KNOWN IRRITANTS

DRUGS: ASPIRIN ___ PENICILLIN ___ SULFA ___ OTHER ___
FOODS: MILK ___ WHEAT ___ SEAFOOD ___ NUTS ___
INHALANTS: DUST ___ POLLEN ___ ANIMAL DANDER ___ PERFUME ___ SMOKE ___ MOLD ___
CONTACT: WOOL ___ COSMETICS ___
ENVIRONMENT: WORKPLACE ___ HOBBIES ___
OTHERS: TEMP ___ WIND ___ WEATHER ___ EXERCISE ___ EMOTIONS ___ INSECTS ___

ENVIRONMENTAL/SOCIAL HISTORY:

DO YOU SMOKE? Y / N PACKS PER DAY _____
DOES ANYONE IN YOUR HOME SMOKE? Y / N WHO? _____
DO YOU DRINK ALCOHOL? Y / N TYPE / FREQUENCY _____ CAFFEINE? Y / N _____
DO YOU USE RECREATIONAL DRUGS? Y / N _____
DO YOU LIVE IN (CHECK ONE) HOUSE ___ APARTMENT ___ HOW MANY PEOPLE? _____
WHAT TYPE OF HEATING SYSTEM DO YOU HAVE? _____ AC _____
DO YOU HAVE ANY PETS? Y / N _____
KIND _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER MEDICINES:

NAME, DOSE, TIMES PER DAY:

MD PREVIEW: _____ DATE: _____

SKIN TEST CONSENT

Purpose: Skin tests are done to determine if the body is making IgE (an allergy antibody) that recognizes environmental factors such as pollen, mold, animal dander.... These agents may be causing your symptoms.

Technique: using a Multi- Test panel we apply a small drop of the protein (ie. Pollen) we want to test, and prick the skin on your back lightly to "introduce" the protein beneath your skin. If there is an IgE antibody that recognizes the agent we have applied to your skin, there will be swelling of the skin within 20 minutes. The swelling and redness around it are measured in millimeters and each is individually recorded. These measurements are then classified on a scale of 0-4 with a 4 being the highest. Intradermals (ID's) are done if prick test are negative. This technique involves using a small needle to inject a bubble under the skin of your forearm. ID's are not done for foods. To obtain a control/ positive before testing we will place a saline and histamine prick onto your arm.

Risks: The risks of applying a small amount of protein on the skin are minimal. The reaction is normally a small bump with some redness. It is possible, but extremely rare to have a life threatening allergic reaction to skin testing. If you have had a life threatening reaction to a food we will not put that food on your skin. We do skin testing in controlled environment with the doctor present and emergency equipment available in case of a reaction.

Materials: We use products form Hollister –Steer, Greer laboratories, and ALK-Abello. They contain glycerol to preserve the antigen.

How much time is needed for testing? : Tests are read twenty minutes after it is placed on the back. Please allow 1 1/2 – 2 hours for this appointment which will include appropriate avoidance techniques for allergies, information about immunotherapy (allergy shots) and a follow-up with the doctor. We will give you a copy of the skin test and one will be mailed to your PCP.

Can pregnant women be tested? Our policy is not to test women who are pregnant. If you are pregnant or think you may be pregnant please let us know prior to the test. If you have any questions please ask the nurse.

Insurance Coverage: Please check with your insurance if the test is covered. It is to your advantage and is your responsibility to be aware of your insurance plan and benefits. Our office will obtain authorization should it be necessary. We do request payment at the time of service. The cost depends on the number of pricks/ID's that are done.

When do we not test: People with asthma who are wheezing or coughing should not be tested unless the doctor determines that your lung functions are adequate for safety. Persons on beta blockers, which is a type of high blood pressure medicine, must consult with their PCP to see if a temporary medicine without beta blocker can be taken. Antihistamines may interfere with the test. Person must be off antihistamines for at least 5-7 days prior to test date. Person must also be off any herbs as they can contain some kind of antihistamines. **Please see attached sheet of the medications that you should avoid 5-7 days prior you test date!!!!**

I have read and understand the risks of skin test and agree to the procedure. I know that I can ask questions from Dr. Blessing-Moore and /or her staff at any time.

Signature: _____ Date: _____
(Parents must sign for minor)
Patient Name: _____ Witness: _____

The following is a list of medications that should be avoid at least for 5-7 days prior to your skin test date. If you are not sure of a certain medication please call our office (650) 688-8480 or (650) 696-8236.

ANTI HISTAMINES

Allegra or Allegra D
Claritin or Claritin D
Clarinex
Ah Chew or Ah Chew D
Zyrtec/ Cetirizine
Xyzal/ Levocetirizine
Benadryl
Atarax
Atrohist
Bromfed
Deconamine
Kronofed
Meclizine
Phenergen
Rynatan or Rynatan P
Rynatuss
Tanafed
Tussi 12
Extendryl or Extendryl SR & JR
Periactin
Semprex or Semprex D
Vistaril

OVER THE COUNTER ANTI HISTAMINES

(may not include all)

Actifed
Aka-Seltzer Cold & Cough
BC Allergy Sinus Cold Power
Benadryl
Chlor- Trimeton
Contac
Comtrex
Dramamine
Drixoral Cold & Flu
Excedrin PE
Extra strength Bayer PM
Nyquil
Nytol
Pedicare Cough & Cold
Sinutab Sinus & Allergy
Sleepinal
Sudafed Cold & Allergy
Tavist or Tavist D(Allergy & Decongestant)
Thera-flu (nighttime)
Triaminic
Tylenol PM/Allergy/Flu

EYES DROPS

Visine A
Naphcon A
Optivar
Patanol
Optimine

NASAL SPRAYS

(may not include all)

Astelin, Astepro, Patanase

ULCER MEDICATIONS (H2 Blockers)

Pepcid
Zantac
Axid
Tagamet
Trinilin

ANTIDEPRESSANT MEDICATIONS

Amitriptyline (Elavil)
Amoxapine (Asendin)
Desipramine (Norpramin)
Doxepin (Sinequan)
Fluoxetine (Prozac)
Imipramine(Tofranil)
Maprotylline(Aventyl)
Protriptylline (Vivactil)
Trazadone(Desyrel)
Trimiprimine (Surmontil)

ANTI-LEUKOTRINES

Singulair/ Monteleukast
Accolate
Zyflo

BETA BLOCKERS (may not include all)

Acebutolol (Sectral)
Atenolol (Tenormin/Tenorectic)
Betaxolol(Betopic/Kerlone)
Bisoprolol(Zebeta/Ziac)
Carteolol(Cartol)
Esmolol(Brevibloc)
Labetolol (Normodyne/Trandate)
Levobunolol(Belagan/Liquifilm)
Metoproilo(Lopressor/Toprol)
Nadolol(Corgard/Cordzide)
Pindolol(Visken)

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