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 ELLLSWORTH 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 TOWRDS 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: _____

FATHER / GUARDIAN'S NAME: _____
DOB: _____ SSN: _____
EMPLOYER: _____WORK _____PHONE:_____
OCCUPATION: _____
_____

MOTHER / GUARDIAN'S NAME: _____
DOB: _____SSN:_____
EMPLOYER: _____WORK PHONE: _____
OCCUPATION: _____
_____

PRIMARY CARE PHYSICAN
NAME: _____
ADDRESS_____ CITY: _____STATE:____ZIP:_____
REFERRED BY: _____
OTHER PHYSICAINS INVOLVEDIN CARE: _____
_____
ADDRESSES: _____
_____
PHONE NO: _____

INSURANCE INFORMATION

HMO___PPO___MEDICARE___MEDICAL___PRIVATE___ (PLEACE 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 APPLICLABLE) *********

EMERGENCY CONTACT PERSON: _____
NAME: _____RELATIONSHIP:_____
PHONE NO: _____

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 you 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 contact.
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 herby 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 SYMTOMS 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: ARRYTHMIA __ 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___HIN1___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:_____

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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.

ANTIHISTAMINES
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 ANTIHISTAMINES
(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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