Donald N. Leibner, M.D.

Patient Information Form

Personal Information

Date of Appt.: _____

Last Name: _____ **First & Middle Names:** _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home/Family Phone #:_____ - _____ - _____ **Work**/Other Phone #:_____ - _____ - _____Ext.#: _____ Sex: *M / F*

Cell Phone #____-____-_____ Marital Status: *Mar /Sngl /Wid / Div / Sep* **Date of Birth**:_____ **Soc.Sec.#**: _____-____-_____

Is Patient a FULL-TIME or PART-TIME **College Student**? Yes / No If so, **School** Name, City, & State:_____

When calling to inform you of lab or radiology results, may we leave a message on your phone? (circle one) **Yes** / **No** If yes, circle your preferred phone: **Home** / **Cell**

Insurance and Employment Information

Some Names or Information may be the same in multiple questions. In these cases, please simply indicate as such.

Name of Employed #1:_____

Employer #1:_____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone #: _____

Employed Person is: *Patient / Spouse / Father / Mother / Other*

Name of Employed #2: _____

Employer #2: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone #: _____

Employed Person is: *Patient / Spouse / Father / Mother / Other*

Primary Insurance Company: _____ Which employer provides this insurance? #1 #2 Neither

Insur. Co.'s Phone #: ____ - ____ - _____ Member's I.D. #: _____ Group #: _____ Plan/Policy #: _____

Insured Person: _____ Insured Person's Soc. Sec.#: ____-____-_____ Insured's Date of Birth: _____ Sex:*M/F*

Address: _____ City: _____ State: ____ Zip: _____

Secondary Insurance Company: _____ Which employer provides this insurance? #1 #2 Neither

Insur. Co.'s Phone #: ____ - ____ - _____ Member's I.D. #: _____ Group #: _____ Plan/Policy #: _____

Insured Person: _____ Insured Person's Soc. Sec.#: ____-____-_____ Insured's Date of Birth: _____ Sex:*M/F*

Address: _____ City: _____ State: ____ Zip: _____

Financially Responsible (*Billed*) Party: _____ Date of Birth: _____ Sex:*M/F* Soc. Sec.#: ____-____-_____

Billing Address: _____ City: _____ State: _____ Zip: _____

Phone #:_____ - _____ - _____ **Billed Party is** (Circle One): Husband Wife Father Mother Son Daughter Guardian Self / Other

Other Important Information

Family/General Doctor: _____

(Full name, address, phone #, and Fax #, if known)

Referred By (circle one): *Doctor / Other:*_____

(Full name, address, phone #, and Fax #, if known)

Person to contact in case of emergency: _____ Phone #1:____-____-_____ Phone #2:____-____-_____

Pharmacy Name: _____ Pharmacy Location: _____ Pharmacy Phone #:____ - ____ - _____

Release of Information

1) I certify that the information I have provided is correct. I authorize the release of any medical information necessary to process this claim. I permit a copy of this release to be used in place of the original.

1) Signed: _____ **Date:** _____

Assignment of Benefits

2) I authorize payment (assignment) of medical benefits to the provider.

2) Signed: _____ **Date:** _____

[Rev. 12/12]

DONALD N. LEIBNER, M. D.
PATIENT MEDICAL HISTORY

Patient's Name: _____ **Age:** _____ **Date:** _____

Please Check Any of the Following:

Nasal/Sinus Symptoms:

- ☐ None
- ☐ Itching / Sneezing / Congestion
- ☐ Post Nasal Drip
- ☐ Sinus Pressure, Pain, or Infections
- ☐ Foul Breath or Taste Throughout the Day
- ☐ Headaches
- ☐ Other: _____

Eye Symptoms:

- ☐ None
- ☐ Itching
- ☐ Redness
- ☐ Tearing
- ☐ Discharge
- ☐ Swelling of the Eyelid or of the White of the Eye
- ☐ Other: _____

Chest Symptoms:

- ☐ None
- ☐ Coughing
- ☐ Wheezing
- ☐ Tightness
- ☐ Chest Congestion
- ☐ Repeated Episodes of Bronchitis
- ☐ Cough/Wheeze/Shortness of Breath after Exercise
- ☐ Other: _____

Skin Symptoms:

- ☐ None
- ☐ Eczema
- ☐ Itching
- ☐ Hives (Welts)
- ☐ Other: _____

Other Allergic Symptoms: _____

_____

_____

When Are Symptoms Worsened?:

(Check Appropriate Boxes - If Not Sure, Mark "?")

TIME OF DAY:

☐ Morning ☐ Afternoon ☐ Night

SEASONS:

- ☐ December/January/February
- ☐ March/April
- ☐ May/June
- ☐ July/Early August
- ☐ Late August/September
- ☐ October/November

WHEN EXPOSED TO:

- ☐ Dusty Areas ☐ Moldy/Musty Areas
- ☐ Dogs ☐ Cats ☐ Other Animals
- ☐ Your Home ☐ Your Workplace or School
- ☐ Indoors ☐ Outdoors
- ☐ Second Hand Smoke or Perfumes
- ☐ Certain Foods: _____
- ☐ Other: _____

How long have you had these Symptoms?

_____

_____

List Any Other Medical Conditions You Have

(Heart/Lungs/Blood Pressure/Intestines/Neurologic/Hearing/etc.)

_____

_____

_____

Do You / Did You Ever Smoke? ☐ No ☐ Yes

If Yes, #Packs/Day _____ # of Years _____

If stopped, when? _____

Are you,or might you be, pregnant? ☐ No ☐ Yes

Medication Listing

List Medications You Are CURRENTLY Using:

_____

_____

List Other Medications which HAVE Helped You:

_____

_____

List Other Medications which HAVE NOT Helped You:

_____

_____

Other Treatments You Have Received for Symptoms:

_____

Name of Your Regular (General) Medical Doctor:

_____

ARE YOU TAKING ANY HEART OR BLOOD PRESSURE MEDICATIONS? ☐ No ☐ Yes (Specify)

_____

PAST MEDICAL HISTORY:

- ☐ Prematurity
- ☐ Colic
- ☐ Wheezing
- ☐ Repeated Ear Infections
- ☐ Surgery
- ☐ Hospitalizations for Asthma
- ☐ Problems with Infant Formulas: _____
- ☐ Other: _____

Medication Allergies?: ☐ No ☐ Yes (Specify)

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Any Other Relevant Problems or Points:

_____

_____

_____

FAMILY ALLERGY HISTORY

	Hayfever	Asthma	Sinuses	Bronchitis	Migraines
Mother.....					
Father.....					
Grandmothers.....					
Grandfathers.....					
Siblings.....					
Children.....					

DONALD N. LEIBNER, M. D.
PATIENT ENVIRONMENTAL SURVEY

Patient's Name: _____ Age: _____ Date: _____

Please Check Any of the Following That May Apply (or Mark a "?" If Unsure):

HOME/LIVING QUARTERS:

BUILDING:
- ☐ Apartment
- ☐ House Age of House _____ years

Do you have a Basement? ☐ Yes ☐ No
If Yes, the Basement is: ☐ Dry ☐ Musty/Damp/Wet
Is there a Dehumidifier in the Basement? ☐ Yes ☐ No
The Home is Near: ☐ Woods ☐ Open Fields
☐ Marsh/Wetlands ☐ Industry: type _____

HEATING / AIR CONDITIONING SYSTEM:
Type of System:
- ☐ Baseboard Heat
- ☐ Individual Room Air Conditioners
- ☐ Steam Heat Radiators
- ☐ Central (Forced Air) Heat
- ☐ Central (Forced Air) Air Conditioning

If Forced Air, What Type of Filter is in the System?
- ☐ Disposable Fiberglass (Standard Blue Woven Fiber)
- ☐ High Efficiency Disposable (eg.:SpaceGard)
- ☐ Electronic / Electrostatic
- ☐ Foam / Washable
- ☐ Other: _____

How Often is the Filter Changed/Cleaned? every _____

Type of Humidifier: ☐ None
☐ Central: ☐ Atomizer Type ☐ Drum Type
☐ Room: ☐ Ultrasonic (silent) ☐ Mist (noisy)
Do You Use Distilled or Filtered Water? ☐ Yes ☐ No
How Often is the Humidifier Cleaned? every _____

TYPES OF FLOOR COVERINGS IN LIVING AREAS:
(Living room, Family room, etc. - NOT bedrooms)
- ☐ Wall to Wall Carpeting - Age of Carpeting _____ years
- ☐ Wood Floors
- ☐ Area Rugs
- ☐ Tile Floors

How Often are Floors Cleaned?
☐ Steam ____ ☐ Vacuum ____ ☐ Damp Mop _____

PATIENT'S BEDROOM:

TYPE OF FLOOR COVERING IN BEDROOM:
- ☐ Wall to Wall Carpeting - Age of Carpeting _____ years
- ☐ Wood Floors
- ☐ Area Rugs
- ☐ Tile Floors

How Often are Floors Cleaned?
☐ Steam ____ ☐ Vacuum ____ ☐ Damp Mop _____

WINDOW COVERINGS IN BEDROOM:
- ☐ Horizontal Blinds ☐ Mini Blinds ☐ Standard
- ☐ Vertical Blinds
- ☐ Shades (Roll Up/Pull Down)
- ☐ Pleated Shades
- ☐ Curtains or Drapes

How Often are Window Coverings Cleaned? every _____

PATIENT'S BEDDING:
Type of Bed:
- ☐ Regular Bed (with Box Springs) ☐ Water Bed
- ☐ Platform Bed ☐ Infant Mattress

Plastic or Vinyl Zippered Cases on Bedding? ☐ Yes ☐ No

Type of Pillows On the Bed (ALL pillows on the bed):
☐ Polyester/Dacron ☐ Foam ☐ Feather (Down)
If Pillow is Cleaned, How Often? every _____

Type of Blanket:
- ☐ Standard Blanket (Synthetic, Cotton, or Wool)
- ☐ Polyester Filled Comforter
- ☐ Down Comforter
- ☐ If Blanket is Cleaned, How Often? every _____

DUST COLLECTORS:
Amount of Clutter in the Bedroom:
☐ Minimal ☐ Medium ☐ Much
☐ Shelves ☐ Books ☐ Papers ☐ Clothes
☐ Stuffed Animals ☐ Knick-Knacks
Are Dresser Tops Cluttered? ☐ Min. ☐ Med. ☐ Much
How Often Room Dusted? every _____

IRRITANT EXPOSURE:

ANIMAL EXPOSURE:
Is the Patient Exposed to Pets or Animals? ☐ Yes ☐ No
If Yes, What Kind of Animals _____
If Yes, With What Frequency _____

SMOKE EXPOSURE:
Is the Patient Exposed to Smoke? ☐ Yes ☐ No
If Yes, With What Frequency _____
If Yes, Who Smokes _____

WORK/SCHOOL EXPOSURE:

What Type of Work Does Patient Perform?
☐ Student ☐ Home Maker ☐ Pre-Schooler
☐ Work (specify): _____

Type of Work Environment: ☐ Office ☐ Factory
☐ Other (specify): _____

Exposure at Work/School/Home: ☐ Dust ☐ Smoke
☐ Chemicals ☐ Other Fumes _____

DONALD N. LEIBNER, M.D., FAAAAI

Adult and Pediatric Allergy and Asthma

579A Cranbury Road, Suite 103, East Brunswick, NJ 08816

(732) 390-4900

▶▶ ▶▶ ▶▶ ▶▶ ▶▶ ▶▶ PLEASE READ THIS LETTER CAREFULLY UPON RECEIVING IT. ◀◀ ◀◀ ◀◀ ◀◀ ◀◀ ◀◀

Dear Patient / Patient's Guardian,

Your appointment has been confirmed. *Please see the accompanying "email cover letter" for the date and time of this appointment.* Please print out and complete the three attached forms and *bring them with you* to your first visit. By doing this, you will help me to better diagnose and treat you (or your child).

It is important that you **bring *any and all* medical insurance cards** that you / your family may have (primary *and* secondary). IF YOUR INSURANCE REQUIRES A REFERRAL, *YOU MUST OBTAIN A REFERRAL FROM YOUR DOCTOR.*

DUE TO A LACK OF COURTESY OF SOME PERSONS (i.e."NO-SHOWS"), THE FOLLOWING POLICY HAS BECOME NECESSARY:

***** A *large* block of time (*approximately 1 hour 20 minutes*) has been set aside for your visit. You *MUST* notify us *at least* 48 hours in advance if you need to cancel your appointment!**

Persons who break "new patient appointments" (i.e. "no-shows") without notifying us will be billed for the full cost of a consultation and testing, since that time could not be used to help other patients.

As a reminder, please remember to not take (or give to the patient) any antihistamines (allergy pills) or Astelin for five days prior to this visit. Also do not take any MAO inhibitors, tricyclic antidepressants, over-the-counter sleeping pills, "nighttime pain relievers," cold tablets, or cough medicines for three to four days prior to this visit, unless you have "OK'd" them with me. These medicines may interfere with your allergy testing. Please continue your other medications, such as asthma medications, as prescribed by your doctor. IF YOU TAKE ANY "BETA-BLOCKER" HEART, BLOOD PRESSURE, OR MIGRAINE MEDICATIONS, CALL US *PRIOR TO* YOUR VISIT.

As a courtesy to our patients with asthma, please ***refrain from wearing perfume or fragrances (or even strong hairsprays) on the day of your appointment. Fragrances may trigger asthma attacks in sensitive individuals.

If you have any questions, feel free to call my office.

Sincerely,

Dr. Leibner

DIRECTIONS

We are located on Cranbury Road, ½ mile south of Ryders Lane / ¼ mile north of the Post Office. ***Our building (579A) is set back from the road* - located directly behind the "579" building.** You will see a **purple sign** on the road with large white letters reading: "579 / 579A - CRANBURY PROFESSIONAL PARK" on your right. Turn **right into the driveway** and *continue straight to the back of the lot* (579A) where you will see parking and the building entrance.

From Route 18 South: (*Do not* take the Cranbury Road exit unless you are familiar with it.) Take **ROUTE 18 SOUTH** to the Rues Lane exit [just after the Brunswick Square Mall (Macy's, J.C. Penny's, Barnes & Noble, etc.)] and make a **RIGHT turn onto RUES LANE.** (This road will wind and twist and will become RYDERS LANE.) At the THIRD traffic light on Rues/Ryders Lane, make a **LEFT turn onto CRANBURY ROAD.** Continue on Cranbury Road for 1/2 mile. Follow the directions above.

From Route 18 North: Take **ROUTE 18 NORTH** to the **RUES LANE** "jughandle." Cross over Route 18 and continue on Rues Lane/Ryders Lane as described above.

From Route 1 South: Take **ROUTE 1 SOUTH**, ¾ mile past the Route 18 interchange (½ mile past the large Sears sign) to the **RYDERS LANE** exit toward East Brunswick. Once on Ryders Lane, go 4.7 miles to **CRANBURY ROAD. Turn RIGHT**; go ½ mile to 579A Cranbury Road (on the right). Follow the directions above.

From **ROUTE 1 NORTH:** Take **ROUTE 1 NORTH** to the **RYDERS LANE** exit toward East Brunswick. Proceed to Cranbury Road as described above.

From Cranbury Road (heading North): Take **CRANBURY ROAD NORTH**, past the Middlesex County Fairgrounds (& "The Chateau" across the road), past Fern Road, and *through* the Lexington Avenue/Cornwall Drive intersection. Continue for 0.8 miles past this intersection. Go **right onto RYDERS LANE** and make a quick right into the "**U-turn**" jughandle lane. This will place you on **RUES LANE.** Go to the 2nd light and make a **LEFT** back onto **CRANBURY ROAD** (heading south). Continue for ½ mile. The office is on the right.