## ALLERGY AND IMMUNOLOGY OF DALLAS

# PATIENT INFORMATION FORM

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| Today’s date: | | | | | | Referring Physician: Referring Physician’s Phone #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Last Name: | | | | | | | | | | | | | | | | First: | | | | | | | | | | | | | | Middle: | | | | | | | ❑ Mr.  ❑ Mrs. | | | | | | | ❑ Miss  ❑ Ms. | | | | | | Social Security # | | | | | | | | |
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| Sex: | | | | | Age: | | | | | | | | | | | |  | | | | | Birth date: | | | | | | | | | | Marital status (circle one) | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| ❑ Male | | ❑ Female | | |  | | | | | | | | | | | |  | | | | | / / | | | | | | | | | | Single / Married / Divorced / Separated / Widowed | | | | | | | | | | | | | | | | | | | | | | |  | |  | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home Phone # | | | | | | | | | | | | | | | Cell Phone #: | | | | | | | | | | | | |
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| P.O. Box: | | | | | | | | | | | | | | | | | | | | City: | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | ZIP Code: | | | | | | | | | | |
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| Language Spoken: | | | | | | | | | | | | | | | | | | | | Race:  ❑ American Indian ❑ Asian ❑ Black ❑ Caucasian | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| ❑ English ❑ Spanish ❑ Other:\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | ❑ Hispanic ❑ Pacific Islander ❑Other: ❑ Decline | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Referred to office by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | | |  | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | ❑ Hospital | | | | |
| ❑ Family | | | ❑ Friend | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | | | ❑ Internet | | | | | | | | | | | ❑ Other | | | | | |  | | | | | | | | | | | | | | | | |
| Are there other family members that are seen here: | | | | | | | | | | ❑ No ❑ Yes Name(s): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pharmacy Name: | | | | | | | | | | Pharmacy Phone #: ( ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***(Please give your insurance card to the front desk)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Responsible Party: | | | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | Home Phone #: | | | | | | | | | | | | | |
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| Is this person a patient here? | | | | | | | | ❑ Yes | | | | | | ❑ No | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Patient Covered By Insurance: | | | | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please ✓Primary Insurance: | | | | | | | | | ❑ AMERIGROUP | | | | | | | | | | | | | | | ❑ AETNA | | | | | | | | | | ❑ BCBS | | | | | | | | | ❑ CIGNA | | | | | | | | | ❑ HUMANA | | | | | | |
| ❑ MEDICAID | | | | ❑ MEDICARE | | | | | | | | | | | ❑ PARKLAND | | | | | | | | | | | | ❑ UNITED HEALTHCARE | | | | | | | | | | | | | | | | ❑ Other: | | | | | |  | | | | | | | | | |
| Subscriber’s Information | | | | | | | | | Subscriber’s Name | | | | | | | | | | | | | | | | | Birth date: | | | | | | | | | Group Number: | | | | | | | | | | Policy Number: | | | | | | | | Co-payment: | | | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | ❑ Self | | | | | | | | | | | ❑ Spouse | | | | | | ❑ Child | | | | | | ❑ Other | | | | |  | | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | | Group Number: | | | | | | | | | | | Policy Number: | | | | | | | |
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| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | | | ❑ Spouse | | | | | | ❑ Child | | | | | | ❑ Other | | | | |  | | | | | | | | | | | | | | | | | | |
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| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | | Home Phone #: | | | | | | | | | | | Cell Phone #: | | | | | | | | |
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| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ALLERGY AND IMMUNOLOGY OF DALLAS or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Date | | | | | | | | | | | | | | | | |  |

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| HEALTH HISTORY | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | |
| Patient’s Name: | |  | | 🞎 M 🞎 F | | | DOB: | |
| revious or referring doctor: | | |  | |  | | | | |
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| **PERSONAL HEALTH HISTORY** | | | | | | | | | | |
|  | | | | | | | | | | |
| List Any Medical Problems Patient Has | | | | | | | | | | |
| Year | Problem/Diagnosis | | | | | Physician | | | | |
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| List Any Previous Surgeries Patient Has Had | | | | | | | | | | |
| Year | Reason | | | | | Hospital | | | | |
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| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | |
| Name of Drug | Strength | Frequency Taken |
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| Allergies to medications | | |
| Name of Drug | Reaction You Had |  |
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| **FAMILY HEALTH HISTORY** | | | | | | | |
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|  |  | |  |  |  | | Other (List) |
| Father |  | | Allergies: Yes or No | Asthma: Yes or No |  |  |  |
| Mother |  | | Allergies: Yes or No | Asthma: Yes or No |  |  |  |
| SIBLINGS | 🞎 M 🞎 F |  | Allergies: Yes or No | Asthma: Yes or No |  |  |  |
| 🞎 M 🞎 F |  | Allergies: Yes or No | Asthma: Yes or No |  |  |  |
| 🞎 M 🞎 F |  | Allergies: Yes or No | Asthma: Yes or No |  |  |  |
| 🞎 M 🞎 F |  | Allergies: Yes or No | Asthma: Yes or No |  |  |  |
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| **SOCIAL HISTORY** | | | | |
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| Is there any smoke exposure at home? | 🞎 | Yes | 🞎 | No |
| Are there any pets at home? | 🞎 | Yes | 🞎 | No |
| Who does the patient live with? |  |  |  |  |
| Is patient currently in school? | 🞎 | Yes | 🞎 | No |
| What grade? |  |  |  |  |
| What is patient’s occupation? |  |  |  |  |
| **OTHER PROBLEMS** | | | | |
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| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. | | | | |

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| --- | --- |
| Eyes: □ Normal □ Abnormal Describe: |  |
| Ears: □ Normal □ Abnormal Describe: |  |
| Nose: □ Normal □ Abnormal Describe: |  |
| Mouth: □ Normal □ Abnormal Describe: |  |
| Throat: □ Normal □ Abnormal Describe: |  |
| Thyroid: □ Normal □ Abnormal Describe: |  |
| Neck: □ Normal □ Abnormal Describe: |  |
| Heart: □ Normal □ Abnormal Describe: |  |
| Chest: □ Normal □ Abnormal Describe: |  |
| Gastrointestinal Tract: □ Normal □ Abnormal Describe: |  |
| Liver: □ Normal □ Abnormal Describe: |  |
| Kidneys/Urinary Tract: □ Normal □ Abnormal Describe: |  |
| Bone/Muscle/Joints: □ Normal □ Abnormal Describe: |  |
| Skin: □ Normal □ Abnormal Describe: |  |
| Nervous System: □ Normal □ Abnormal Describe: |  |

**ALLERGY & IMMUNOLOGY OF DALLAS**

**INSURANCE RE-IMBURSEMENT NOTIFICATION**

Please be aware that your insurance will only pay for services that are specifically covered under your insurance policy.   
  
An allergy evaluation, endoscopy, examination, injections, inhalation treatment, testing, and serum may be deemed necessary by the doctor to adequately treat or diagnose your condition. Insurance may fail to cover certain care when it is considered preventative or pre-existing. In this situation your insurance may deny said coverage. We will try to notify you in advance of any tests or procedures that may not be covered or subject to your deductible and/or co-insurance.

It is impossible to know the limitations of all individual insurance policies or their pre-existing conditions. Consequently, if you are not notified in advance that a test or procedure will not be covered, that does relieve you of your financial responsibility.

An estimate of the doctors charges for possible non-covered office visits, procedures or tests are available upon request.

**Beneficiary Agreement**

I have been notified by my physician that certain services may be denied by my insurance. If insurance denies payment, I agree to be personally and fully responsible for the payment.

I have also been advised that the doctor does not bill my insurance for Aerosol sinus treatment ($20) or steroid injection ($25), making me responsible for payment at time service is received.

FAILURE TO CANCEL APPOINTMENT OR NO SHOW CHARGE IS $25.00.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient / Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Beneficiary or Person Financially Responsible Witness

**PATIENT CONSENT FORM**

***Use of Disclosure of Health Information for Treatment, Payment or Healthcare Operations***

I understand that as part of my healthcare, Allergy and Immunology of Dallas, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Allergy and Immunology of Dallas, ***Notice of Privacy Practices***, provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy or access to the ***Notice of Privacy Practices*** and understand that I have the right to review the notice prior to signing the consent. I agree that Allergy and Immunology of Dallas is not required to agree to the restriction requested. I may revoke this consent at any time in writing except to the extent that Allergy and Immunology of Dallas has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

\_\_\_\_\_\_I request the following restrictions on the use and/or disclosure of my personal health information.  
  
  
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I further understand that any and all records, whether written or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.   
  
I have been provided or reviewed Allergy and Immunology ***Notice of Privacy Practices***   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  
Signature of Patient or Responsible Party Date Print Name of Witness Date  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Print Name of Patient or Responsible Party

***OTHER THAN STATED ABOVE, I AUTHORIZE RELEASE OF INFORMATION VERBAL/WRITTEN TO:***

I hereby give permission to Allergy and Immunology of Dallas to disclose and discuss any information related to me or my child’s medical condition(s) to the following family member(s), other relative(s), and/or close personal friend(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name Relationship

# Patient Instruction/Consent Form for Allergy Skin Testing

**Skin Test**: Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:  
**Prick Method:** The skin is pricked with plastic brackets that contain drops of allergens to certain pollens, molds, dust mites, animal dander and when applicable, certain foods.

**Intradermal Method:** This method consists of injecting small amounts of an allergen into the superficial layers of the skin.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient’s clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms. You will be tested to important airborne allergens (depending on your location) and possibly some foods. These include trees, grasses, weeds, molds, dust mites, and animal dander. The skin testing generally takes 20-30 minutes. Prick (also known as percutaneous) tests are usually performed on your back but may also be performed on your arms. Intradermal skin tests may be performed if the prick skin tests are negative and are performed on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit.  
  
You may be scheduled for skin testing to antibiotics, venoms, or other biological agents. The same guidelines apply.

## DO NOT

1. No prescription or over the counter oral antihistamines should be used 7-10 days prior to your scheduled skin testing. These include cold tablets, sinus tablets, hay fever medications, or oral treatments for itchy skin, over the counter allergy medications, such as Claritin, Zyrtec, Allegra ,Actifed, Dimetapp, Benedryl, and many others. Prescription antihistamines such as Clarinex and Xyzal should also be stopped at least 7-10 days prior to testing. If you have any questions whether or not you are using an antihistamine, please call our office and ask to speak with the nurse. In some instances a longer period of time off these medications may be necessary.
2. You should discontinue your nasal and eye antihistamine medications, such as Patanase, Pataday, Astepro, Optivar, or Astelin at least 2 days before the testing. In some instances a longer period of time off these medications may be necessary. If you have any questions whether or not you are using an antihistamine, please call our office and ask to speak with the nurse.
3. Medications such as over the counter sleeping medications (e.g. Tylenol PM) and other prescribed drugs, such as amytriptyline hydrochloride (Elavil), hydroxyzine (Atarax), doxepin (Sinequan), and imipramine (Tofranil) have antihistaminic activity and should be discontinued at least 2 weeks prior to receiving skin test after consultation with your physician.

## YOU MAY

1. You may continue to use your intranasal allergy sprays such as Flonase Rhinocort, Nasonex, Nasacort. Omnaris, Veramyst and Nasarel.
2. Asthma inhalers (inhaled steroids and bronchodilators), leukotriene antagonist s (e.g. Singulair, Accolate) and oral theophylline (Theo-Dur,T-Phyl, Uniphyl, Theo-24, etc.) do not interfere with skin testing and should be used as prescribed.
3. Most drugs do not interfere with skin testing but make certain that your physician and nurse know about every drug you are taking (bring a list if necessary).

Skin testing will be administered in our office with a medical physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; and generalized itching.   
  
Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing will be postponed until after the pregnancy. Beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

***Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.***

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment

We request that you do not bring small children with you when you are scheduled for skin testing unless they are accompanied by another adult who can sit with them.

# Consent Form for Allergy Skin Testing

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed\_\_\_\_\_\_\_\_\_\_

Parent or legal guardian\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed\_\_\_\_\_\_\_\_\_\_

\****as parent or legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.***

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed\_\_\_\_\_\_\_\_\_\_\_\_