

Dear Patient,

Enclosed are your New Patient Forms. **This information must be completed prior to your visit.** Please bring them with you on the date of your visit along with your insurance card. (Do not mail in.)

If your insurance requires a referral, please make sure this has been called into your primary care physician and bring the information along with you to your visit. **If you do not have this information on the date of your visit, your appointment will have to be rescheduled for another day.**

To be tested, please note: **You must not be on any antihistamines or decongestants 48 hours to 1 week prior to your appointment.** ******(See *attached list*)****** Medications do not have to be stopped if coming in for hives. Asthma medications can be continued. Please check with our office if you are unsure.

Thank you for your consideration. We look forward to seeing you in our office.

PHYSICIAN SEEING: DR. PANUTO DR. RAMBASEK

DATE OF APPOINTMENT: _____

TIME: _____ OFFICE LOCATION: _____

(Medication list on back)