Seshagiri Rao, M.D., P.A.

Board Certified in Allergy & Immunology

3016 Communications Pkwy. Suite #100 Phone: 972-964-7373

Plano, TX 75093 Fax: 972-964-3939

rao.aatc@gmail.com

www.allergyandasthmatreatmentcenter.com

Welcome to Dr. Rao's office! We know that a lot of thought and consideration goes into choosing the right physician to suit your needs, and we sincerely appreciate the confidence and trust you have placed in us. We know that your time is valuable, so to make the time spent in our office as useful as possible, please follow the instructions below:

- Please fill out the forms provided and either mail or fax them back to our office **at least one week before your appointment.** These forms are:
  - Registration Form (if not already completed on the patient portal)
  - Medical Questionnaire
  - Signed consent forms

- Additionally, please include the following:
  - Include a copy of the patient's insurance card (front and back), with the patient's name and date of birth written on the copy. Using this, we can verify your benefits prior to your appointment and address any related problems ahead of time.
  - If we are seeing your child, please include a recent photograph for your child's chart. Dr. Rao uses this as a visual aid when talking to you on the phone.
  - Include copies of any lab reports or testing done in the past that you would like Dr.Rao to review (i.e.: blood, urine, stool, or allergy testing.) **Note that any tests that have not been sent to our office one week prior to your visit will not be discussed at the time of your appointment**
  - If you have a child that may wish to make use of our play area, please also include the *Play Area Waiver* (downloadable from our website).
- We've provided a *Notice of Privacy Practices* on our website. Please review these before signing the appropriate.
- **When scheduling your appointment, please make a window of time available that may be longer than the appointment length. We see a large number of patients from all over Texas and the United States, many of whom have special needs. Each patient takes a different amount of time, and while we do try to run on time, please understand that circumstances do not always allow this.**

When you send your information back to us, please mark it "Attention Lori / Kam." Again, we look forward to your upcoming visit. Please don't hesitate to call our office if you have any questions. Thank you for choosing the Allergy and Asthma Treatment Center and Dr. Rao!

ALLERGY AND ASTHMA TREATMENT CENTER- REGISTRATION FORM

(If not already completed through patient portal)

Patient's name: _____

Date of Birth: _____/_____/_____ Gender: _____

SSN: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Primary Contact Information:

Name: _____ Relationship: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Insurance Information:

Insurance company: _____ Plan name: _____

ID number: _____ Group number: _____

Effective date: _____ Patients relationship to policy holder: _____

Policy holders name: _____

Policy holders DOB: _____

Symptoms:

- _____
- _____
- _____

Medications:

- _____
- _____
- _____

Allergies (Drug, Food, Environmental):

- _____
- _____
- _____

Smoking status: _____

Emergency contact:

Name: _____ Relationship: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Primary Care Provider:

Name: _____ Number: _____

Pharmacy information:

Name: _____ Number: _____

Address: _____

School information (if applicable)

Name: _____

Phone number: _____

I the patient ( ) Parent ( ) Guardian ( ) give permission for complete diagnostic evaluation and all treatment necessary to be performed by the physician and or staff. I hereby authorize payment directly for Dr.Rao for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance and for all services rendered on my behalf or my dependant's behalf.

Signature: _____

Date: _____

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Appointment Cancellation Policy

All Cancellations of existing appointments have to be made at least by 9:00 am of the prior business day. (For example, an appointment scheduled for 2:00 pm on Wednesday should be cancelled by 9:00 am on Tuesday.) You may speak to a staff member, leave a voice mail message or send us an email/fax requesting a cancellation.

Failing to do so will make it necessary for us to charge a cancellation fee of $75.00 to your account. This fee is not negotiable.

I have understood the appointment cancellation policy of your office. I will pay a cancellation fee if applicable.

_____

Sign

_____

Seshagiri Rao, M.D.
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Plano, Texas 75093
(972)964-7373

Acknowledgement of Reviewing Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Patient Name

_____

Signature

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/ or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drug purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescription that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

SESHAGIRI RAO, MD
Allergy, Asthma, & Immunity Disorders

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Insurance Information and Records Agreement

I, _____, agree that the information pertaining to the health insurance coverage of myself or a dependant which I have provided to the office of Dr. Seshagiri Rao, MD is correct and complete to the best of my knowledge. I fully understand that to the extent that any of the aforementioned health insurance information I have provided is incorrect or incomplete, *I am fully responsible for any resulting charges.*

Furthermore, I am aware that when any changes to my policy information occur, I bear the responsibility of informing the office so that I may fill out a change of insurance form. I understand that should I fail to notify the office of changes to my policy, *I am fully responsible for any resulting charges.* Additionally, I agree to maintain a copy of any information given to the office and any explanation of benefits provided by my insurance company for future reference with respect to billing matters.

Patient/Subscriber Signature Date:

_____

Office Staff Signature Date:

_____

Telephone Policy

- We *do not provide medical care* over the phone or by email. If you have a medical need we advise you to make an appointment
- Urgent medical problems will be addressed by phone on a case by case-by-case bases
- Changes in current medication and prescriptions for new medications **require an office visit**
- Lab results will be accessible through our patient portal and will be discussed at your scheduled office visit. If you have any questions regarding this information you must make an appointment to talk with the doctor.
- If you are having a medication side effect or ineffectiveness we will be happy to see you immediately.
- Do not call asking to talk to the doctor, or to have the doctors call you back. They see patients throughout the entire day. If you want to talk to the doctor you must make an appointment. Messages left for the doctor will be dealt with on an urgent basis and will usually result in a request of an office visit.
- Telephone consult fees will be based on Dr. Rao's preparation and actual time on the phone.

We want to provide you excellent, personal, medical care!

I have read and understand this telephone policy

Parent/Guardian's Signature: _____ Date: _____

Patient's Name: _____

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Full and Complete Release

I, the undersigned parent, desire to use the sensory play area adjacent to the waiting room to reinforce the sensory related skills for my child. I understand that I am expected to supervise my child during his participation using the play equipment. I do understand how to use the equipment and I have been explained to my satisfaction the proper use of the equipment.

I agree that Dr. Rao and his staff shall not be liable to any injuries, damages, or losses whether actual or potential, growing out of or claimed to grow out of using the facility, including but not limited to claims of pain, suffering, mental or emotional anguish, loss of income, medical expenses, and consequential damages.

I, the undersigned parent, for my heirs, executors, agents, representatives, administrators, and assigns do hereby release and forever discharge Seshagiri Rao, M.D., P.A. and its staff members, directors, managers, officers, successors, assigns, employees, servants, agents, independent contractors, attorneys and representatives from any and all claims, demands, and causes of action, known or unknown which were or might have been asserted or which I have, might have had, or might have been in the future arising out of or in any way connected with my participation in the facility.

I further state that I have read this full and complete release in its entirety, fully understand its content and effect, and am signing it of my own free choice. I further represent that no other statements or representations, oral or written, have induced me in any way to sign this full and complete release or form any part of the consideration for my signature.

IN WITNESS WHEREOF I have signed this Full and Complete Release on the _____ day of _____ in the year _____.

_____

Parent's Name

_____

ALLERGY AND ASTHMA TREATMENT CENTER- NEW PATIENT (PARENT) ALLERGY AND ASTHMA QUESTIONNAIRE

PLEASE PRINT THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT

PATIENT NAME: _____ DATE OF BIRTH: / / DATE: / /

Please describe the reason for the visit today:

- _____
- _____
- _____

Past Medical History:

Medical Diagnosis	Prior Hospitalizations (if any)	Date and Place of Hospitalization

- **Immunization:** Are your immunizations up to date? _____Yes _____No (if YES, please list approximate dates)

Pneumococcal vaccine? _____/_____/_____ Flu shot? _____/_____/_____ Tetanus toxoid _____/_____/_____

- **Surgery:** Have you ever had any of the following surgeries in the past? (Please list approximate dates)

Sinus Surgery? _____/_____/_____ Tonsillectomy/Adenoidectomy? _____/_____/_____

Ear tube placement? _____/_____/_____ Other surgeries _____/_____/_____

Have you ever been prescribed and Epi-pen? _____Yes _____No
Are you on any special diet? _____Yes _____No
If yes what kind of diet? _____

HISTORY OF PRESENT ILLNESS.

Please circle all related symptoms you are experiencing

SKIN:	-Eczema	**EARS:**	-Difficulty hearing	**THROAT/MOUTH:**	-Post nasal drip	-Difficulty getting air in
	-Hives		-Itchy ears		- Sore throat	-Difficulty getting air out
	-Contact allergies:				-Phlegm	
	Poison Ivy	**NOSE:**	-Stuffy Nose		-Mouth breathing	
	Poison Oak		-Runny Nose		-Loss of taste	
	Latex		-Itchy Nose			
			-Frequent sneezing	**SINUS/FACIAL:**	-Sinus congestion	
			-Nose bleeds		-Sinus pressure	
			-Snoring		-Sinus pain	
			-Nasal polyps			
			-Loss of smell			
				RESPIRATORY:	-Shortness of breath at rest	
					-Shortness of breath with exercise	
					-Wheezing	
					-Cough	
					-Chest tightness	
					-Night time awakenings	

Have you ever been diagnosed with Asthma? _____Yes _____No

- If yes, year diagnosed_____

Ever been allergy skin tested/allergy blood tested? _____Yes _____No

- If yes when and where were they done? _____

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? _____Yes _____No
When: _____ How much: _____

Please circle any exposure to the following that make your symptoms worse.

Dust	Feather	Insecticide	Aerosol sprays
Cats	Dogs	Pet Dander	Smoke
Pollution	Smog	Grass	Cold Air
Humidity	Exercise	Perfumes	Other Symptoms:

When are your symptoms worse? Please circle all that apply.

January	February	March	April	May	June
July	August	September	October	November	December

Are your symptoms better away from home? _____ Yes _____No
Have you had any recent labs done pertaining to an allergy/asthma evaluation? _____Yes _____No

- If yes what labs were done? When and where were they done? _____

Recent X-rays? Chest or CT of Sinus or Chest _____Yes _____No

- If yes what was done? When and where were they done? _____
- History of allergy shots/allergy drops? _____Yes _____ No

- If so how long ago were they completed? _____

- Have you ever had an immune workup done? Yes _____ No _____
- Please describe: _____

ASTHMA: (if not applicable, please skip this portion)

- What kind of treatment have you already received for asthma? _____
- How frequently do you have asthma exacerbations? _____
- How often do you use your rescue inhaler? _____
  - Have you ever been intubated? YES _____ NO _____
- Any ER visits or hospitalizations due to this condition? YES _____ NO_____
  - When: _____ Location: _____
- How many times have you needed steroids (pills or injections) for asthma exacerbations? _____
- Recent X-rays? Chest or CT of Sinus or Chest _____Yes _____No
  - If yes what was done? When and where were they done? _____

ECZEMA OR RASHES: (if not applicable, please skip this portion)

- Location of rash _____
- How long have you had the rash? _____
- What medicines have you used for the rash? _____
- What soaps/ lotions do you use? _____

HIVES OR SWELLING: (if not applicable, please skip this portion)

- Location of symptoms_____
- Please describe your symptoms _____
- How long have you had these symptoms? _____
- Have you had a biopsy? _____

<u>If Patient is a Child:</u>

- Birth weight: _____ lbs _____ oz Birth place: _____
- Duration of pregnancy _____ weeks Hours of active labor: _____

- Was the delivery: _____ Vaginal ____ Caesarean ___ Water birth
- List any complications that were experienced during or after birth

  _____

- Was the initial feeding: _____Bottle _____Breast; If breast, for how long? _____
  - If bottle, what type of formula was used? _____ for how long? _____

- At what age was the child first introduced to solid foods? _____
- Did the patient have any intolerance to any foods such as milk, eggs, peanuts, etc.? _____YES NO_____
  - If yes please explain: _____

- As an infant did the patient have (check all that apply)

Colic	Constipation	Constant runny nose
Eczema	Reflux/Vomiting	Breathing problems
Any formula changes	Chronic infections	Other:

DURING PREGNANCY, DID THE MOTHER:

- Smoke? _____ YES _____NO If yes # of cigarettes per day? _____ Length: _____
- Drink? _____ YES _____ NO If yes what kind and how often? _____
- Use illicit drugs? _____ YES _____NO If yes what kind and how often? _____
- Use of prescription medication? ____ YES _____ NO Name of medication: _____
- Any other children? _____ YES ____NO Names and Ages: _____

Social History:

- Occupation: _____
- Who lives with you at home (parents, siblings, etc.)? _____
- Do you exercise? ____YES ____NO
- If yes, how often? _____
- Do you currently smoke? ____YES ____NO
  If yes # of cigarettes per day? _____ Length: _____
- Do you use any recreational drugs? ____YES ____NO
  If yes what kind and how often? _____
- Marital Status: Single Married Divorced Widowed
- Work/ School Name: _____
- Do you drink alcohol? ____YES ____NO
  If yes what kind and how often? _____
- Have you in the past? ____YES ____NO
  If yes # of cigarettes per day? _____ Length: _____
- Are you adopted? ___Yes ___No
  If yes, at what age? _____

Family History: (Please list any family members that have/ are suffering from any of the following conditions)

MEMBER	Age	Alive?	Allergies	Eczema	Hives or swelling of skin	Asthma	Immune Deficiency
MOTHER							
FATHER							
BROTHERS							
SISTERS							
PATERNAL GRANDPARENTS							
MATERNAL GRANDPARENTS							

Environmental History:

- What kind of house do you live in? _____ House _____ Apartment _____ Mobile Home
- Is your house built on a slab? ____YES ____NO
- Types of trees/greenery around your home? _____
- Do you have any kind of pets? _____ Yes ____No

If yes, what kind and how many? _____

- Type of flooring in your bedroom? _____
- Is there anyone that smokes in your home? ____YES ____NO
- Where do they smoke? _____ Indoors _____ Outdoors
- What type of pillows do you use (i.e. feather, down, etc.) _____
- Do you live in the _____city _____ suburbs _____rural area
- Approximate age of your home? _____
- What kind of air conditioning do you have? _____ Central Air _____Window Units
- Type of heating system (check one) _____ Hot Air _____ Steam _____Electric _____ Hot water
- What type of comforter do you have? _____
- Do you have allergy proof encasing for pillow or mattress? ____Yes ____No

Review of Systems:

Do you experience any of the following symptoms? (Please, **check all** that apply)

***Symptoms other than related to allergies**

Ears
____Decrease hearing
____ Ringing in ears
____ Earache
____Drainage, type

Eyes
____Redness
____Blurry or double vision
____ Discomfort
____ Glaucoma
____ Tearing
____ Photophobia
____ Cataracts

Mouth and Throat
____Sore throat
____Dry mouth
____Sore tongue
____Hoarseness
____Thrush
____Throat tightness
____Sensation of "sticking" in throat
____Excessive drooling
____Throat clearing

Nose
____ Stuffiness
____Discharge
____ Itching
____Nosebleeds
____Sinus pain/pressure
____ Post Nasal Drip
____Snoring
____ Mouth breathing

General
____ Fever
____ Chills
____ Fatigue
____ Daytime Sleepiness
____Insomnia
____Weakness

Gastrointestinal
____ Swallowing difficulties
____Heartburn
____Change in appetite
____ Nausea
____ Change in bowel habits
____Rectal bleeding
____Constipation
____Diarrhea

Dermatologic
____Rashes
____Lumps
____Blisters
____Boils (Abscess)
____Itchiness
____Dryness
____Skin color change
____Hives

Immunology
____Immune Deficiency
____Recurrent pulmonary infection
____Recurrent sinus infections
____Recurrent skin infections

Neurologic
____Dizziness
____Stroke
____Fainting
____Seizures
____Weakness
____Numbness
____Tingling
____Tremor
____Headaches, type
_____