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

Board Certified in Allergy & Immunology

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

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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

_____

PANS/PANDAS NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Expectations from today visit:

_____

_____

Thank you for taking the time to provide a carefully thought out history

CURRENT HISTORY:

- Main Concerns about your child today:

1) _____

2) _____

3) _____

- Brief course of treatment of your child's illness:

_____

_____

_____

_____

- Does your child suffer from the following symptoms? Indicate the approximate date and age of onset

Symptoms	Experienced	Date and age of onset	Resolved (Yes or No)	Comments (use back if necessary)
Anxiety	Yes ( ) No ( )			
Tics (verbal, nonverbal)	Yes ( ) No ( )			
Obsessive/repetitive behavior	Yes ( ) No ( )			
Intrusive thoughts	Yes ( ) No ( )			
Anger/ Rage	Yes ( ) No ( )			

Irrational fears	Yes ( ) No ( )			
Attention deficit	Yes ( ) No ( )			
Decrease in ability to learn	Yes ( ) No ( )			
Headaches	Yes ( ) No ( )			
Gastrointestinal tract symptoms	Yes ( ) No ( )			
Urinary frequency	Yes ( ) No ( )			
Urinary incontinence	Yes ( ) No ( )			
Bowel incontinence	Yes ( ) No ( )			

Triggers: Please describe if you have noticed changes in your child's symptoms from exposure to any of the following

Type	Experienced	Comments
Infections	Yes ( ) No ( )	
Exposure to sick family members	Yes ( ) No ( )	
Vaccination	Yes ( ) No ( )	
Dental procedures or loose tooth	Yes ( ) No ( )	
Additional reactions (list below if necessary)	Yes ( ) No ( )	

- Current treatments:
  - Prescriptions:

    _____

    _____

- Supplements:

  _____

  _____

- Diets:

  _____

  _____

- Therapy:

  _____

  _____

PAST MEDICAL HISTORY:

Pregnancy Questions

- Maternal age: _____ years old
- Duration of pregnancy: Full term ____ Yes _____ No If no, how many weeks: _____
- Type of delivery: ____ Vaginal _____ Caesarean ____ Water birth: _____
- Duration of labor: _____ hours _____ hours of active labor
- List any problems that were experienced by the mother during pregnancy or during labor:

  _____
- Did the mother have any illnesses during pregnancy? ____ Yes ____ No
  - If yes, what illnesses? _____
- Did the mother receive any vaccines during pregnancy? ____ Yes ____ No
  - If yes, which vaccines? _____

Newborn Questions:

- Birth weight: _____ lbs _____ oz
- Apgar score (if known): _____ 1 min _____ 5 min
- List any problems observed with the child immediately after birth:

  _____
- Was the initial feeding: _____Bottle _____Breast
  - If breast, for how long? _____ If bottle, 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: _____

- Did the patient have any trouble gaining weight as a child? ____YES ____NO
  - If yes, please explain: _____

Developmental History (skip if not appropriate):

- At what age did you notice developmental problems? _____
- Did your child experience any regressions? _____ Yes ____ No
  - Please describe any regressions experienced by your child:

    _____

    _____
- Gross motor skills (running, jumping, balance, etc.): Advanced Normal Delayed

  If delayed please explain: _____
- Fine motor skills (grasping, hand writing, cutting, etc.): Advanced Normal Delayed

  If delayed please explain: _____
- Sensory skills: Advanced Normal Delayed

  If delayed please explain: _____
- Speech: Advanced Normal Delayed

  If delayed please explain: _____

Infectious Disease History:

- Has your child ever experienced any frequent and/ or unusual infections? ____YES ___NO
  - If yes, please explain type of infection/illness and frequency:

    _____

    _____
- Has your child ever been treated with antibiotics? ____YES ___NO
  - If yes, how many courses and last time they were taken: _____
  - Was a probiotic used when treated with an antibiotic course? ____YES ___NO
- Has your child ever been treated with anti-viral or anti-fungal medications? ____YES ___NO
  - If yes, please explain: _____

Immunization History:

- Has your child received routine immunizations? ____YES ___NO
- Has your child ever experienced a reaction to immunizations? ____YES ___NO
  - If yes, please explain: _____
- Did your child's behavior change after receiving a certain vaccination? ____YES ___NO
  - If yes, please explain when and name of vaccine:

_____

- Did your child experience any loss of skills or regression of skills after being vaccinated? ____YES ___NO
    - If yes, please explain:

      _____

      _____
- Please explain if your child developed any new symptoms after being vaccinated:
    - _____

FAMILY HISTORY

- Does anyone in the family have the same symptoms as the patient? ___ Yes ____ No
    - Please explain if necessary:

      _____

      _____

      _____

Relevant illnesses if any

- Mother: _____
- Father: _____
- Siblings: _____

  _____
- Paternal Grandparents: _____
- Maternal Granparents: _____

SCHOOL PERFORMANCE

- Grade: _____ School Type: _____ Public _____ Private _____ Home School

Name: _____

- School Performance: Excellent Good Fair Poor
- Symptoms during school: ____ Yes ___No if yes, please explain: _____
- Problems during school: ____ Yes ___No if yes, please explain: _____