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

Board Certified in Allergy & Immunology

3016 Communications Pkwy. Suite #100
Plano, TX 75093

Phone: 972-964-7373
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
    - Medical Questionnaire
    - Appointment Cancellation Policy
    - Acknowledgment of Reviewing Notice of Privacy Practices
    - Insurance Information and Records Agreement
- 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.)
    - 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 / Cam." 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!

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

Board Certified in Allergy & Immunology

Registration Form

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Email address:	Home phone:	Cell phone:	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Work phone no.: ( )

City:	State:	ZIP Code:

Referred by: (please check box):	❑ Dr. _____	❑ Insurance ❑ Hospital

❑ Family ❑ Friend _____	❑ Yellow Pages _____	❑ Other _____

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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.

Patient/Guardian signature *Date*

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

Board Certified in Allergy & Immunology

3016 Communications Pkwy. Suite #100
Plano, TX 75093

Phone: 972-964-7373
Fax: 972-964-3939

RAO.AATC@GMAIL.COM

WWW.ALLERGYANDASTHMATREATMENTCENTER.COM

PATIENT'S NAME: _____ DOB:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

1. When was your child first diagnosed with a developmental disorder?
   _____
2. Was there a specific diagnosis made and if so what method was used?
   _____
3. What physician made the diagnosis?
   _____
4. At what age did you notice that your child's development was not normal?
   _____
5. Please list your child's symptoms:
   _____
6. Did your child lose language skills? If so, when?
   _____
7. Did your child lose social interaction skills? If so, when?
   _____
8. Does he/she have any gastrointestinal issues? If so, pleased detail:
   _____
9. Is your child on a gluten/casein free diet? If so, for how long?
   _____

10. Has your child ever had Secreting, IVIG, or chelation therapies? If so, please list which ones and briefly describe the results:

    _____

11. Does your child have any allergies to your knowledge? If so, has any allergy testing been performed in the past?

    _____

    _____

12. Please list your child's strengths:

    _____

    _____

    _____

    _____

13. Please list your child's challenges:

    _____

    _____

    _____

    _____

14. Please list all family members of the household, including pets:

    _____

    _____

    _____

    _____

15. Please list any present therapies, including type, locations, and hours per week:

    _____

    _____

    _____

    _____

16. Was your pregnancy full-term? If not, please specify:

    _____

    _____

    _____

    _____

17. During the pregnancy did you experience any illnesses?

    _____

    _____

_____

18. Did you receive either the Rhogam or flu vaccines during pregnancy?

_____

19. Did you consume any fish during your pregnancy? If so, what type and how much?

_____

_____

_____

20. Do you have any amalgam (metal) fillings? If so, how many?

_____

21. How long was your labor?

_____

22. What was your baby's APGARS?

_____

23. What was your child's birth weight?

_____

24. Was the baby breast-fed? If so, for how long? If bottle fed, with what formula?

_____

_____

25. From 0-6 months:
    Were all milestones met? _____
    Were all immunizations done? _____
    Any illnesses: _____

26. From 6-12 months:
    Were all milestones met? _____
    Were all immunizations done? _____
    Any illnesses: _____
    Walked when?: _____

27. From 1-2 years:
    Were all milestones met? _____
    Were all immunizations done? _____
    Communications with others: _____

28. From 2-3 years: Any unusual behaviors or routines?

_____
_____
_____

29. From 3-4 years: Any unusual behaviors or routines?

_____
_____
_____

30. Please list any other information you would like us to be aware of:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Board Certified in Allergy & Immunology

3016 Communications Pkwy. Suite #100
Plano, TX 75093

Phone: 972-964-7373
Fax: 972-964-3939

rao.aatc@gmail.com

www.allergyandasthmatreatmentcenter.com

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

_____

Date

Seshagiri Rao, M.D.
3016 Communications Parkway, Ste. 100
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

_____

Patient Signature

Seshagiri Rao, M.D., P.A.
Board Certified in Allergy & Immunology
3016 Communications Pkwy. Suite #100
Plano, TX 75093
Phone: 972-964-7373
Fax: 972-964-3939
rao.aatc@gmail.com
www.allergyandasthmatreatmentcenter.com

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:

_____