Mid-Cities Allergy & Asthma Center

New Patient Welcome Letter

Dear New Patient:

Welcome to our practice! Thank you for choosing Mid-Cities Allergy & Asthma Center for your allergy and asthma care. Since you are a new patient to us, we would like to introduce ourselves and familiarize you with our practice. Both Dr. Venkatesh and Dr. Wust are board certified in Allergy & Immunology and have been practicing in North Texas since 2003. Our health service goals are to deliver high-quality, cost-effective and individualized care plans that promote the health and well-being of the patients we serve.

We realize you have high expectations from your physicians, and our first and foremost goal is to exceed those expectations. Your initial visit with the Allergists at Mid-Cities Allergy & Asthma Center will involve a detailed consultation with the physician, possible testing, and a tailored treatment plan. This individualized care can result in a new patient appointment lasting **2-3 hours**. When making your new patient appointment, please budget your time accordingly. It is very helpful if you have all your new patient forms completely filled out beforehand. If you prefer to fill out your forms at our office, please arrive 30 minutes prior to your appointment time.

Please bring all medications and supplements that you are currently taking to your initial appointment. Also bring or arrange to have sent any relevant medical records **prior** to your appointment so that our physicians have the time to review them. We recommend the following: sinus or chest x-ray films or reports, sinus or chest CT scan films or reports, laboratory results, any previous allergy testing or lung function tests (i.e. spirometry).

Due to the nature of our practice, we ask that patients refrain from wearing perfume and other fragrances which can irritate sensitive individuals. Our office is a smoke-free environment and smoking is not permitted anywhere in the building or near entryways. Due to our patients with food allergies, no food is permitted in the waiting room or exam rooms. We ask that you please respect these policies in the best interest of all our patients.

With all of the information and education you will undoubtedly receive after your visit at Mid-Cities Allergy & Asthma Center, it is easy to feel overwhelmed. Please feel free to call our office with any questions you may have after your consultation.

Again, thank you for choosing Mid-Cities Allergy & Asthma Center. Drs. Venkatesh and Wust and the staff at Mid-Cities Allergy look forward to a wonderful relationship with you and your family.

Sincerely,
The Doctors and Staff at
Mid-Cities Allergy & Asthma Center

Mid-Cities Allergy & Asthma Center

New Patient Registration Form

PATIENT INFORMATION

Full Legal Name (First)	(MI)	(Last)	(Nickname – if any)

Street Address (No.) (Street Name)	(Apt.)	Date of Birth (MM/DD/YYYY)	Age	Sex

City	State & Zip Code	Driver's License Number	State of Issue	Race or Ethnicity	Marital Status

Cell Phone	Home Phone	Work Phone	E-mail Address	Employer

Referring Doctor	Primary Care Doctor	Preferred Pharmacy	Emergency Contact
Name:	Name:	Name:	Name:
Phone:	Phone:	Phone:	Phone:
Address:	Address:	Street:	Relationship:

Contact Information

(1) May we contact you at home? YES ☐ NO ☐
(2) May we contact you at work? YES ☐ NO ☐
(3) Check the boxes below, where we may leave messages about your care, such as appointment reminders, test results, or other healthcare information.

Family Member	YES ☐	NO ☐	Friend	YES ☐	NO ☐
Home Answering Machine	YES ☐	NO ☐	Work Voicemail	YES ☐	NO ☐
Personal Cell Phone	YES ☐	NO ☐	Co-Worker	YES ☐	NO ☐

Medical Information Disclosure

I hereby give permission to Mid-Cities Allergy & Asthma Center to disclose any information related to my medical conditions to the following person or entity (e.g., spouse, significant other, friend, relative, school nurse, employer, etc.), until revoked by me in writing:

Name of Person or Entity	Relationship to Patient

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (First)	(MI)	(Last)	(Phone Number)

Street Address (No.) (Street Name)	(Apt.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Patient's relationship to the Responsible Party

INSURANCE INFORMATION

Primary Insurance Company (Name)	(Insured's/Subscriber's ID or Member No.)	(Insured's Group No.)

Primary Insurance Company (Claims Address)	(Phone Number)

Insured's Name (First) (MI) (Last)	Patient's relation to the Insured? ☐ Self ☐ Spouse ☐ Dependent

If the Insured or Subscriber is not the Patient or Responsible Party, then complete the requested information below:

Insured's (Street Address)	(Apt.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Insured/Subscriber's Relationship to the Patient

If the Patient is covered by a Secondary Insurance Policy, then complete the requested information below:

Secondary Insurance Company (Name)	(Insured's/Subscriber's ID or Member No.)	(Insured's Group No.)

Secondary Insurance Company (Claims Address)	(Phone Number)

Insured's Name (First) (MI) (Last)	Patient's relation to the Insured? ☐ Self ☐ Spouse ☐ Dependent

If the Insured or Subscriber of the Secondary Insurance is not the Patient or Responsible Party, then complete the requested information below:

Insured's (Street Address)	(Apt.)	Date of Birth	Age	Sex

City	State	Zip Code	Social Security No.	Insured/Subscriber's Relationship to the Patient

Mid-Cities Allergy & Asthma Center

Health Questionnaire

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female
Primary Care Physician: _____ Tel: _____
Referring Physician: _____ Tel: _____
How did you hear about our practice? ☐ Physician ☐ Family or Friend ☐ Insurance ☐ Internet
☐ Phone Book ☐ Ad ☐ Other: _____

Briefly describe the reason for your visit today: _____
_____
_____

Current Medications:

Allergy/Asthma:
(Name/Dose/Frequency)

All Others:
(Name/Dose/Frequency)

Medication Allergies: Med Name: _____ Reaction: _____
Med Name: _____ Reaction: _____
Med Name: _____ Reaction: _____

Previous allergy testing: ☐ No ☐ Yes If Yes, when? _____ Results: _____
Previous allergy shots: ☐ No ☐ Yes If Yes, when? _____ Helpful? _____

Environmental History: Do you live in a ☐ House ☐ Apartment ☐ Dorm ☐ Trailer ☐ Other_____
Carpet: ☐ Yes ☐ No
Pets: ☐ Dogs How long? _____ ☐ Cats How long? _____
☐ Other animals: _____
Type of pillow: ☐ Feather/Down ☐ Synthetic ☐ Other _____
Dust covers? ☐ No ☐ Yes If yes, covers for: ☐ pillows ☐ mattress ☐ box spring

Social History: Do you currently smoke? ☐ No ☐ Yes If yes, how long? _____ Packs per day _____
Are you a former smoker? ☐ No ☐ Yes If yes, how long? _____ Packs per day _____
When did you quit? _____
Are there smokers in the household? ☐ No ☐ Yes If yes, who? _____
Occupation: _____
If the patient is a child, does he/she attend daycare? ☐ No ☐ Yes ☐ Other _____

2305 Central Park Blvd. * Bedford, TX 76022 * (817) 571-6622 phone * (817) 868-1962 fax

Mid-Cities Allergy & Asthma Center

Name: _____ Date: _____

Past Medical History: Do you have a history of (please check all that apply): ☐ High Blood Pressure ☐ Diabetes
☐ Acid Reflux ☐ Thyroid disease ☐ Chronic Bronchitis ☐ Migraines ☐ Glaucoma
☐ Coronary Artery Disease/Congestive Heart Failure ☐ Immunodeficiency
List other medical conditions: _____
_____
_____
_____
_____

Past Surgical History: Sinus Surgery ☐ No ☐ Yes when _____ Ear Tubes ☐ No ☐ Yes when_____
Tonsillectomy ☐ No ☐ Yes when _____ Adenoidectomy ☐ No ☐ Yes when _____
Other Surgeries: _____
_____
_____

Review of Systems: Please **circle** any signs or symptoms you are **currently** experiencing:

Constitutional:	Fatigue	Night Sweats	Chills	Fevers	
Eyes:	Pain	Glaucoma	Cataracts	Strabismus	Dry
Ears:	Pain	Vertigo	Infections	Ringing	Loss of hearing
Nose:	Nosebleeds	Deviated Septum	Ulcers	Polyps	Loss of smell
Throat:	Pain	Frequent clearing	Thrush		
Respiratory:	Wheeze	Cough	Tight chest	Shortness of breath	
Cardiovascular:	Chest pain	Palpitations	Slow/fast heart rate		
Gastrointestinal:	Heartburn	Vomiting	Diarrhea	Reflux	Trouble swallowing
Genitourinary:	Blood in urine	Kidney stones	Discharge	Urine infections	
Skin:	Blistering	Dry	Itch	Hives	Swelling
Neurological:	Numbness	Seizures	Migraines		
Hematology:	Easy bruising	Easy bleeding	Swollen lymph nodes		
Endocrine:	Weight gain	Weight loss	Increased thirst	Cold/heat intolerance	
Musculoskeletal:	Stiff/sore joints	Muscle pain	Red/swollen joints		
Psychological:	Anxious	Depressed	Stressed	ADD/ADHD	

Family History:

	Father's Side	Mother's Side	Siblings
Asthma	_____	_____	_____
Hay Fever	_____	_____	_____
Eczema	_____	_____	_____
Hives/Swelling	_____	_____	_____
Migraines	_____	_____	_____
Immunodeficiency	_____	_____	_____
Other	_____	_____	_____

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Medications That Can Block Skin Test Results

If using any medication on this list, STOP 5 days prior to skin testing
Please Note: Most cough, cold, allergy, flu, and sleep aids will block allergy testing

Generic Name	Brand Name(s)
Oral Antihistamines	
Cetirizine	**Zyrtec**, Zyrtec-D, Aller-Relief
Desloratadine	**Clarinex** and Clarinex-D
Fexofenadine	**Allegra** and Allegra-D
Levocetirizine	**Xyzal**
Loratadine	**Claritin, Alavert**, and Tavist ND
Diphenhydramine	**Benadryl,** Actified Sinus Day, Banophren, Dephedryl, Diphen, Dytan, and many others
Hydroxyzine	**Vistaril, Atarax**, and Rezine
Dexchlorpheniramine	Polaramine
Cyproheptadine	Periactin
Chlorpheniramine	Aller-Chor, C.P.M., Chlor-Amine, Chlor-Al Relief, Chlor-Mal, Chlor-Phenit, **Chlor-Trimeton**, Chlorphen, Effidac-24, and Ridraman
Clemastine	Allerhist-1, **Contac** 12-Hour Allergy, **Tavist**
Carbinoxamine	Palgic, Palgic-DS, Rondec, Rondec-TR, and Andehist-NR, **Karbinal ER, RyVent**
Brompheniramine	Bromphen and Bromphed PD
Azatadine	Optimine
Doxylamine	**Nyquil**
Nasal Sprays	
Azelastine	**Astelin** and **Astepro** nasal spray
Azelastine/Fluticasone	**Dymista**
Olopatadine	**Patanase** nasal spray
Eye Drops	
Alcaftadine	**Lastacaft**
Azelastine	**Optivar**
Olopatadine	**Pataday, Pazeo, Patanol**
Bepotastine	**Bepreve**
Epinastine	Elestat
Ketotifen	**Zaditor**, Alaway

Generic Name	Brand Name(s)
Sleep Aids	
Diphenydramine	Calm-Aid, Compoz Nightime Sleep Aid, **Nytol**, Sominex, Twilite, **Tylenol PM, Advil Pm, Aleve PM, Unisom** sleepgels, **Zzzquil**
Trazadone	**Desyrel, Oleptro**
Anti-Nausea (anti-vomiting)	
Meclizine	**Antivert**
Promethazine	**Phenergan**
Prochlorperazine	**Compazine**
Antacids (indigestion)	
Ranitidine	**Zantac**
Famotidine	**Pepcid**
Cimetidine	Tagamet
Nizatidine	Axid
Herbal Supplements	
Licorice, Green Tea, Saw Palmetto, **St. John's Wort**, and Feverfew.	
Anti-Depressants	
Amitriptyline	Elavil
Doxepin	Sinequan
Desipramine	Nurpramin
Nortriptyline	Aventyl
Trazadone	Desyrel
Imipramine	Tofranil
Protriptyline	Pamelor or Vivactil
Mirtazapine	Remeron
Nefazadone	Serzone
Clomipramine, Trimipramine, amoxapine, and maprotiline	
***If you have any concerns about stopping your anti-depressant, or other medications on this list, please continue your medications and discuss with the doctor at your appointment.**	

Mid-Cities Allergy & Asthma Center

Medical Services Financial Agreement

Thank you for choosing Mid-Cities Allergy & Asthma Center for your health care needs. It is our hope that the following financial policies will be helpful and reduce misunderstanding or confusion as we pursue payment for the medical services we provide. Please speak to a receptionist if you have any questions regarding these policies.

Payment for Services
Payment for services is due at the time services are rendered. For patients without insurance, payment in full is due at the time of service. For patients with insurance, such payment includes any co-payment, deductible, co-insurance, and all fees associated with non-covered services. We accept cash, checks, MasterCard, Visa, Discover, and American Express. Returned checks will result in a **$30** administrative fee that will be posted to your account. Delinquent account balances may be assessed a **$20** late fee every 30 days from the initial statement due date. Returned checks or outstanding balances older than 90 days may be subject to external collection. If it becomes necessary to forward your account to a collection agency, in addition to the amount owed, you will be responsible for all collection fees, attorney and court fees.

Medical Insurance
If we are contracted with your medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this, you must provide our office with all relevant information, including copies of your health insurance card and driver's license. It is your responsibility to make sure we have your current information on file prior to receiving care. This information will be used to verify your insurance benefits. If you are unable to provide complete insurance information for benefit verification, you are responsible for full payment at the time of service.

Please understand that the ultimate responsibility for ensuring complete payment is made lies with you, not your insurance company. As a courtesy to our patients, we will gladly submit your claim to the insurance company. However, we cannot guarantee your insurance will pay these claims since the insurance company will only "quote" your benefits, they never "guarantee" these benefits. If your insurance has not paid a claim within 60 days of billing, any unpaid professional fees are due and payable in full from you within 30 days of your statement date.

Your health insurance is a contract between you, your employer (if applicable), and your insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

Referrals
If you have an insurance plan that requires a referral (e.g., an HMO plan), it is your responsibility to obtain a referral from your primary care provider prior to your first scheduled appointment and keep it current for every visit thereafter.

Cancelled Appointments
Missed appointments represent a cost to us and to other patients who could have been seen in the time that was set aside for you. Therefore, cancellations must be requested at least 24 hours prior to the scheduled appointment time. Failure to cancel or show for a scheduled appointment may result in a **$25** administration fee**.** Failure to cancel or show for a special procedure (e.g., patch testing) may result in a **$50** administrative fee. These fees are not billable to your insurance.

Medical Records
We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Requests for medical records will be processed within 15 business days as mandated by the Texas Board of Medical Examiners and will be subject to a processing fee as determined by the Medical Board.

Medication Refills
Please call your pharmacy to request a refill of your medication(s). Prescription refills may take 2 business days to process. Routine refill requests will not be honored if the patient has not been evaluated by their physician of record within the past 12 months. However, urgent refill requests will be honored with the understanding that the patient must be evaluated by their physician before another refill is required.

Acceptance of the Medical Services Financial Agreement

I have read and understand the Medical Services Financial Agreement above and all questions that I have concerning this agreement have been answered to my satisfaction.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient, Parent or Legal Guardian