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

New Patient Medical History

Only complete this form if the digital version was not completed online within the Patient Portal	
Patient Name:	**Date of Birth:**
Patient Nickname:	**Patient Age:**
If patient is a minor then [Mother's Name]:	[Father's Name]:
Parents of the minor are: ☐ Married ☐ Divorced ☐ Separated ☐ Other:	
Primary Physician:	Referring Physician:
How did you hear about us? (Check the box that applies most)	
☐ Physician ☐ Family/Friend ☐ Insurance Plan ☐ Internet Search ☐ Phone Book ☐ Other:	

MAIN PROBLEM

Briefly describe, in your own words, the main reason for your visit?

How long have you had this problem and what is your main goal for this visit?

REVIEW OF SYMPTOMS

Check-off all symptoms which apply to the patient

General:	☐ fatigue	☐ drowsiness	☐ headache	☐ fevers	☐ chills	☐ sweats
	☐ body aches	☐ malaise	☐ weight loss	☐ weight gain	☐ other:	
Eyes:	☐ itchy eyes	☐ watery eyes	☐ drainage	☐ eye redness	☐ swollen	☐ crusting
	☐ eyelid swelling	☐ eyelid scaling	☐ dry eyes	☐ gritty eyes	☐ eye pain	☐ blurry vision
	☐ vision loss	☐ other:				
Ear, Nose & Throat:	☐ snoring	☐ nasal congestion	☐ itchy nose	☐ runny nose	☐ sneezing	☐ clear drainage
	☐ colored drainage	☐ sinus infections	☐ ear infections	☐ itchy ears	☐ ear pressure	☐ itchy throat
	☐ hoarseness	☐ sore throat	☐ throat clearing	☐ decreased smell	☐ nosebleeds	
	☐ other:					
Chest:	☐ cough	☐ wheezing	☐ chest tightness	☐ chest heaviness	☐ shortness of breath	☐ excessive sputum
	☐ coughing up blood	☐ other:				
Gastro-intestinal:	☐ heartburn	☐ sour burps	☐ nausea	☐ vomiting	☐ diarrhea	☐ constipation
	☐ abdominal pain	☐ abdominal cramps	☐ abdominal bloating	☐ swallowing issues	☐ gas	☐ bowel habit change
	☐ black stools	☐ bloody stools	☐ yellow skin	☐ other:		
Skin:	☐ skin rash	☐ itchy skin	☐ eczema	☐ hives	☐ dry skin	☐ skin infections
	☐ other:					
Additional Symptoms:						

SYMPTOM TRIGGERS

What makes your symptoms get worse? (Check-off any box below that may trigger your symptoms)

Allergy/ENT	Asthma/Chest	Eczema/Hives/Skin	Comments:
☐ does not apply	☐ does not apply	☐ does not apply	
☐ unknown	☐ unknown	☐ unknown	
☐ all year long	☐ all year long	☐ all year long	
☐ spring	☐ spring	☐ spring	
☐ summer	☐ summer	☐ summer	
☐ fall	☐ fall	☐ fall	
☐ winter	☐ winter	☐ winter	
☐ house dust	☐ house dust	☐ sweating	
☐ cats	☐ cats	☐ dry skin	
☐ dogs	☐ dogs	☐ heat	
☐ mowing the lawn	☐ mowing the lawn	☐ cold	
☐ mulching the garden	☐ mulching the garden	☐ medicine or drugs	
☐ food	☐ food	☐ food	
☐ smoke	☐ smoke	☐ personal products	
☐ strong odors	☐ strong odors	☐ scratching	
☐ exercise	☐ exercise	☐ exercise	
☐ indoors	☐ infections	☐ infections	
☐ outdoors	☐ emotional stress	☐ emotional stress	
☐ see comments	☐ see comments	☐ see comments	

New Patient Medical History

ALLERGY & ASTHMA HISTORY

Please answer the following questions

Question			
1) Have you ever been tested for allergies?	☐ No	☐ Yes	If YES, then when (year):
If YES, then what tested positive:			
2) Have you ever been treated with allergy shots?	☐ No	☐ Yes	If YES, then from { } to { }
If YES, did allergy shots help you?	☐ No	☐ Yes	☐ Maybe If YES, then by whom:
3) Have you ever had a CT scan of the sinuses?	☐ No	☐ Yes	If YES, then when (year):
If YES, was sinus CT normal?	☐ No	☐ Yes	☐ Not Sure
If NO or NOT SURE, explain:			
4) Have you ever had nasal or sinus surgery?	☐ No	☐ Yes	If YES, then when (year):
5) Have you ever had a reaction to food?	☐ No	☐ Yes	If YES, then what foods:
If YES, was reaction treated in the ER?	☐ No	☐ Yes	
If YES, please describe reaction:			
6) Have you ever had an insect sting reaction?	☐ No	☐ Yes	If YES, then what insects:
If YES, was reaction treated in the ER?	☐ No	☐ Yes	
If YES, please describe reaction:			
7) Have you ever been diagnosed with asthma?	☐ No	☐ Yes	If YES, then when (year):
If you answered "YES" to question 7 above, then answer questions 8 - 11 below about your asthma			
8) Any ER visits for asthma over the past year?	☐ No	☐ Yes	If YES, then how many visits:
9) Have you ever been hospitalized for asthma?	☐ No	☐ Yes	
If YES, then how many and in what year(s)?			
If YES, did hospitalization result in an ICU stay?	☐ No	☐ Yes	
10) Any missed school or work due to asthma?	☐ No	☐ Yes	If YES, total # of days over the past year:
11) Any oral steroid use over the past year?	☐ No	☐ Yes	If YES, total # of courses over past year:

Allergy and asthma history comments (if any):

INFECTION & IMMUNOLOGICAL HISTORY

Please answer the following questions

Question		
1) Are all recommended immunizations up-to-date?	☐ Yes	☐ No
2) Has lab work ever been done to evaluate the function of your immune system?	☐ No	☐ Yes
3) Has intravenous antibiotic therapy ever been required to clear a serious infection?	☐ No	☐ Yes
4) Have oral antibiotics ever been used for 8 weeks or longer with little or no benefit?	☐ No	☐ Yes
5) Have any antibiotic treatments been prescribed for the patient over the past year?	☐ No	☐ Yes
If YES, then how many courses have been prescribed for the patient over the past year:		

6) Have you had any of the following types of infections over the past 12 months?

Infection			
Sinus infections:	☐ No	☐ Yes	If YES, then how many over the past year:
Ear infections:	☐ No	☐ Yes	If YES, then how many over the past year:
Bronchitis:	☐ No	☐ Yes	If YES, then how many over the past year:
Pneumonia:	☐ No	☐ Yes	If YES, then how many over the past year:
			If YES, then how many episodes of pneumonia over lifetime:
Skin or organ abscesses:	☐ No	☐ Yes	
Oral or cutaneous thrush:	☐ No	☐ Yes	
Other types of infections:	☐ No	☐ Yes	

Infection and immunology history comments (if any):

New Patient Medical History

ENVIRONMENTAL HISTORY

Please answer the following questions

1) Does patient have any routine exposure to environmental tobacco smoke? ☐ No ☐ Yes

2) Does patient have any routine exposure to pets or other animals?
If YES, then what type(s) of animals:

3) Birthplace of patient: 3b) Living in Texas since (year):

4) Living in current residence since (year): 4b) Year in which current residence was built:

5) Description of current residence or work environment: (check-off all that apply)

☐ house (single family)	☐ apartment/multi-unit dwelling	☐ manufactured (mobile)	☐ pier & beam foundation
☐ basement	☐ carpet	☐ wood burning stove/fireplace	☐ water damage/mold growth
☐ indoor plants	☐ indoor pets	☐ rodents	☐ cockroaches/other insects
☐ central HVAC	☐ window AC unit(s)	☐ other notable feature	☐ unknown

6) Description of current sleeping area (bedroom): (check-off all that apply)

☐ spring or pillow-top mattress	☐ memory foam mattress	☐ sleep number mattress	☐ water bed
☐ feather pillow or comforter	☐ carpet	☐ stuffed toys	☐ curtains or drapes
☐ pets allowed in bedroom	☐ pets sleep on the bed	☐ rodents	☐ cockroaches/other insects
☐ air cleaner	☐ ceiling fan	☐ other notable feature	☐ unknown

FAMILY, WORK & SOCIAL HISTORY

Check-off the corresponding boxes and list any medical problems below if it applies

Relationship	Healthy	Allergy	Asthma	List of Other Medical Problems
Mother:	☐	☐	☐	
Father:	☐	☐	☐	
Sister:	☐	☐	☐	
Brother:	☐	☐	☐	
Daughter:	☐	☐	☐	
Son:	☐	☐	☐	

Patient occupation: Second job (if any):

Hobbies, additional work history or comments (if any):

Education level:

Smoking status: ☐ never smoker ☐ former smoker ☐ current smoker
If former or current smoker, then how many packs per day:
If former or current smoker, then for how many years:
If former smoker, then in what year did you stop smoking:

Additional social history of comments (if any):

Only complete this section if the patient is less than 10 years old

BIRTH & EARLY CHILDHOOD HISTORY

1) Was the patient born early or premature?	☐ No	☐ Yes	If YES, was infant placed on a ventilator?
2) Was or is the patient breast fed?	☐ No	☐ Yes	If YES, then for how many months?
3) Did the patient ever have colic?	☐ No	☐ Yes	If YES, then what age did it resolve?
4) Did the patient ever have reflux?	☐ No	☐ Yes	If YES, then did patient require medication?
5) Did patient ever contract RSV?	☐ No	☐ Yes	If YES, did it require hospitalization?
6) Did the patient ever develop eczema?	☐ No	☐ Yes	If YES, then what age did it first develop?
7) Has patient ever attended day care?	☐ No	☐ Yes	If YES, then at what age did they start? If YES, is attendance ongoing?
8) Did patient have normal growth & development?	☐ Yes	☐ No	If **NO**, explain:

Additional birth & early childhood history comments (if any):

New Patient Medical History

PAST MEDICAL & SURGICAL HISTORY

List all medical conditions including the year the diagnosis was initially made

Medical Condition	Year	Medical Condition	Year
(1)		(8)	
(2)		(9)	
(3)		(10)	
(4)		(11)	
(5)		(12)	
(6)		(13)	
(7)		(14)	

List all surgical and sinus procedures including the year the procedure was performed

Surgical Procedure	Year	Surgical Procedure	Year
(1)		(6)	
(2)		(7)	
(3)		(8)	
(4)		(9)	
(5)		(10)	

CURRENT MEDICATION LIST & DRUG ALLERGIES

Please complete if you currently use any prescription, over-the-counter or herbal medications

Name of Medicine	Dose	How Often Do You Take It	What Year Did You Start This Medicine
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			
(7)			
(8)			
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			
(25)			

Please complete the following section if you have any medication allergies

Name of Medicine	Reaction Symptoms	Year of Reaction
(1)		
(2)		
(3)		
(4)		
(5)		

Mid-Cities Allergy & Asthma Center

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