Dear Parent(s),

Welcome to our office. Enclosed, please find your registration materials.

PLEASE COMPLETE THIS PAPER WORK PRIOR TO YOUR ARRIVAL, OR REGISTER ON-LINE: www.okemosallergycenter.com

IMPORTANT: PLEASE REVIEW THE MEDICATION INFORMATION SHEET. FAILURE TO READ THIS INFORMATION MAY CAUSE YOUR APPOINTMENT TO BE RESCHEDULED. PARENTS ARE EXPECTED TO ACCOMPANY THEIR CHILD DURING THE INITIAL CONSULTATION VISIT. IF YOU ARE MAKING ARRANGEMENTS FOR ANOTHER FAMILY MEMBER TO ACCOMPANY YOUR CHILD, PLEASE CALL OUR OFFICE FOR FURTHER INSTRUCTIONS.

PLEASE BRING (OR PROVIDE A DETAILED LIST) OF ALL YOUR CHILD'S MEDICATIONS.

Allow 2 to 3 hours for this appointment.

We require payment of co-payments at the time of service. Allergy testing costs will vary depending on the number of items the patient is being tested for. If your insurance plan has a deductible, please be aware the cost of the allergy testing may be applied to your deductible. We strongly suggest you review your insurance plan and make note of any possible out-of-pocket costs. It is your responsibility to know your insurance plan and coverage details.

If you have any questions, please call our office. We look forward to your visit.

Regards,

Kamal Mohan, M.D.
Lawrence Hennessey, M.D.
Manoj Mohan, D.O.

TO OUR PATIENTS WHO ARE TO BE SKIN TESTED

DO NOT STOP TAKING YOUR ASTHMA MEDICATIONS

Antihistamines and many other medications can interfere with allergy skin testing. Before your visit, please discontinue the following medications for the number of days indicated:

ANTACIDS:
2 Days: Axid, Pepcid, Tagamet, Zantac, Tums Ultra

DO NOT NEED TO STOP:
Prevacid, Prilosec, Nexium

ANTI-ANXIETY/DEPRESSANTS:
1 Day: Limbitrol
3 Days: Elavil (prefer 7 days), Remeron
7 Days: Sinequan (Doxepin)
5 Days: Seroquel

ANTI-NAUSEA MEDICATIONS:
3 Days: Antivert, Compazine, Dramamine, Phenergan, Tigan

MUSCLE RELAXANTS:
5 *Days:* Flexeril

ANTI-HISTAMINES:
2 Days/Prescription: Allegra 60 mg, Allegra-D 12 Hour, Astelin Spray, Patanase Spray, Bromfed, Deconamine, Dimetane, Kronofed, Nolamine, Ornade, Rynatan, Ryna-S 12, Semprex, Trinalin, Fexofenadine 30 mg and 60 mg., Clemastine, Tavist II (Tavist I original formula).

2 Days/Over-the-Counter: Actifed, Benadryl, Brompheniramine, Chlor-Trimeton, Chlorpheniramine, Clemastine, Contac, Dimetapp, Diphenhydramine, Drixoral, Tavist, Excedrin PM

5 Days/Prescription: Allegra 180 mg., Atarax, Periactin, Vistaril (Hydroxyzine), Fexofenadine 180 mg., Allegra D 24 Hr., Xyzal, Cyproheptadine (Periactin).

5 Days/Over-the-Counter: All types of Claritin, Alavert, Loratadine., Zyrtec, Zyrtec D., Tavist Non-Drowsy Formula.

6 Days/Prescription: Clarinex, Clarinex D.

There is no need to discontinue decongestants unless they are combined with antihistamines.

CHILD/DEPENDANT REGISTRATION FORM

(Please Print)

Personal Information

Please check here if your child has ever been seen in our office prior to today's appointment: _____

Patient's Legal Name: _____ Street Address: _____

City: _____ State: _____ ZIP: _____ Hm. Phone: _____

EMAIL ADDRESS: _____ Sex: _____ Date of Birth: _____

Race: _____ Ethnicity: _____

In Case of Emergency Notify:

_____/_____/_____
(Name) (Phone) (Relationship to patient)

Primary Care Physician: _____ Phone: _____

Mother's Legal Name: _____ Social Security No. _____

Mother's Date of Birth: _____

Home Phone: _____ Work Phone: _____

Address (if different from patient's): _____

_____

Father's Legal Name: _____ Social Security No. _____

Father's Date of Birth: _____

Home Phone: _____ Work Phone: _____

Address (if different from patient's): _____

_____

Parent's Marital Status: _____ Married _____Divorced _____ Separated

Preferred Pharmacy: _____

Prescription Drug Plan: _____

INSURANCE INFORMATION

(Please Present All Insurance Cards to Staff)

Primary Carrier: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

Employer's Name: _____ Phone: _____

Employer's Address: _____

INSURANCE INFORMATION CONTINUED

Secondary Carrier: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Contract No. _____ Group No. _____

Co-pay Amount (if any) $_____

Employer's Name: _____ Phone: _____

Employer's Address: _____

FINANCIAL POLICY

Thank you for allowing us to be part of your child's health care team. In order for us to provide the best possible care and to maximize your medical insurance policy coverage, you must provide accurate insurance information. This includes providing current insurance card(s) and informing our staff of any recent changes, including employment, coverage, or address.

The relationship you have with your insurance company and employer is a contract of which we are not part of. As a courtesy, our billing staff will process your claims for you, and answer any questions you may have. **Please be advised that, regardless of your insurance status, final responsibility for payment of our services is your obligation**.

It is the patient's responsibility to make sure proper prior authorizations and referrals are made and updated when needed.

Patients with Blue Cross Blue Shield Master Medical (BCBSM) are required to pay at the time of service. We will process your claim promptly in order for you to receive payment directly from BCBSM.

Special Note for General Motors BCBS PPO Groups: Your plan will cover a portion of the Office Call. For Traditional Groups: Your plan does not cover Office Calls. **All other services, including skin testing, serums and injections, *are not covered by either plan***. If you have any questions, please speak with one of our Billing Specialists.

Co-payments are due at the time of service. A $5.00 Service Charge will be added if you do not pay your Co-Pay at Check-In. If you cannot pay the co-payment today, please notify the receptionist.

We will make every attempt to notify you of your insurance coverage for our services, however, we cannot guarantee coverage for every service. Certain services, such as office calls, serums, injections, or testing may not be covered by your insurance.

The parent who REQUESTS treatment for a child is the parent responsible for all fees for services rendered.

I have read and understand the conditions set forth, and I authorize the treatment of my child and also the release of any medical or other information necessary to process the insurance claim(s). I also request payment of medical benefits be made directly to Okemos Allergy Center, P.C..

_____ _____

(Responsible Party/Subscriber) **(Date)**

GUARANTEE OF PAYMENT FOR SERVICES

In the interest of providing you with uninterrupted quality medical care, we are advising you of the following:

There are some insurance companies that require an authorization before an office visit will be paid; others have their own insurance guidelines about when a visit to a specialist's office will be covered. ***It is your responsibility to know the extent of your insurance benefits and to get any required authorizations in advance of being seen. These authorizations must be in our office at the time of the visit.***

If, for any reason, your insurance company chooses not to cover your office visit or any procedures, you will be responsible for payment at the time of service. This includes all future visits. The estimated cost for a visit can be provided to you in advance.

Your signature below indicates that you will be responsible for payment in full should you fail to obtain an authorization, or should your insurance company choose not to pay for your visit.

I, _____, have read and agree with the above statement, and further agree to be responsible for all charges incurred, or to provide written approval authorization from my insurance company for all visits and procedures prior to being seen.

_____ _____

(**Parent or Guardian signature)** **(Date)**

PATIENT HISTORY FORM

Please Answer Questions that Apply to Your Child

Patient's Name: _____

What are your child's symptoms? Mark an "X" after any of the following which apply to your child. Mark "XX" if severe and "XXX" if extremely severe.

X		Onset Date	X		Onset Date
_____	Coughing	_____	_____	Nasal Blockage	_____
_____	Sore Throat	_____	_____	Wheezing	_____
_____	Runny Nose	_____	_____	Itchy Throat	_____
_____	Shortness Breath	_____	_____	Sneezing	_____
_____	Headache	_____	_____	Chest Pain	_____
_____	Post Nasal Drainage	_____	_____	Eye Itching	_____
_____	Skin Itching	_____	_____	Itchy Nose	_____
_____	Tearing	_____	_____	Skin Rash	_____
_____	Nose Bleeds	_____	_____	Ear Blockage	_____
_____	Hives or Swelling	_____	_____	Loss Taste/Smell	_____
_____	Hearing Loss	_____	_____	Nausea	_____
_____	Diarrhea	_____	_____	Indigestion	_____
_____	Vomiting	_____	_____	Colic/Cramps	_____
_____	Hoarseness	_____	_____	Frequent Colds	_____
_____	Nervousness	_____	_____	Fatigue	_____
_____	Sinus Infections	_____	_____	Insect Reactions	_____

Other: _____

_____

2. Which symptom(s) is/are the most bothersome: _____

_____

3. Does your child have a history of any major diseases? _____Yes _____No If yes, please explain:

_____

_____

4. List hospitalizations:

Date:	Reason
_____	_____
_____	_____
_____	_____

5. Do your child's symptoms change with the seasons? _____Yes _____No If yes, which season(s) is/are worse:_____

6. Do any of the following affect your child's symptoms:

When outdoors	Worse _____	Better _____	No Change _____
When indoors	Worse _____	Better _____	No Change _____
At night	Worse _____	Better _____	No Change _____
On exposure to house dust	Worse _____	Better _____	No Change _____
Sleeping on feather pillows	Worse _____	Better _____	No Change _____
On exposure to freshly cut grass	Worse _____	Better _____	No Change _____
In fields or tall weeds	Worse _____	Better _____	No Change _____
In barns, near hay, or raking leaves	Worse _____	Better _____	No Change _____
After exposure to animals	Worse _____	Better _____	No Change _____
On exposure to tobacco smoke	Worse _____	Better _____	No Change _____
On exposure to hair spray, perfume, or newsprint	Worse _____	Better _____	No Change _____
During or after exercise	Worse _____	Better _____	No Change _____

7. List foods that you suspect cause symptoms and describe the symptoms:

Food	Symptom(s)
_____	_____
_____	_____
_____	_____
_____	_____

8. List all drugs which cause symptoms:

Drug	Symptom(s)
_____	_____
_____	_____
_____	_____
_____	_____

9. Has your child had any lab work (blood tests, urine tests, etc.) or X-rays done recently? ___Yes ___No
   If yes, which tests were peformed? (Please bring in copies of the results if possible.)

   _____

   _____

10. What is your family history regarding allergies?

    _____

    _____

    _____

11. Please list your child's current medications (**MEDICATION NAME / STRENGTH / DOSE):**

    _____

    _____

    _____

    _____

12. Please list allergy medications that your child has tried in the past, but did not work for her (him):

    _____

    _____