TEXAS REGIONAL ASTHMA AND ALLERGY CENTER, L.L.P.

Board Certified specialists in allergy, asthma, immunology, and respiratory disorders

RICHARD A. MAYSE, M.D., RENE ALBERT LEON, M.D., ALI SHAKOURI, M.D., SHARON SETH, M.D.

900 East Southlake Blvd. Suite 300 Southlake Texas 76092

(817) 421-0770 (Main) (817) 421-4759 or (817) 424-8431 (Fax)

WEBSITE: www.traac.org

Dr. Ali Shakouri, MD

NEW PEDIATRIC PATIENT EVALUATION FORM (for patients 16 and under) Date: _____

Name: _____ DOB: _____ Age: _____

Primary Race (please select from list below):
- o African American
- o American Indian or Alaskan Native Native
- o Asian
- o Caucasian
- o Hispanic
- o Native Hawaiian or other Pacific Islander

Secondary Race (if applicable, please select from list below):
- o African American
- o American Indian or Alaskan
- o Asian
- o Caucasian
- o Hispanic
- o Native Hawaiian or other Pacific Islander

Primary reason to be here today: _____

Referring physician: _____ Physician City: _____

PCP (if other than referring doctor): _____ City: _____

Best contact telephone number for you: _____

Birth and development history (if less than 6 years old)

Birth weight: _____
Full-term delivery? Y or N
Delivery type: C-section or vaginal

Any notable problems during or shortly after birth? _____
Was patient breast or bottle fed? _____ If breast fed, how long exclusively? _____
Any problems with feedings or to formula? _____

Day Care? Y or N Age Started: _____ Normal growth curve? Y or N

Are immunizations up to date? Y or N

Past Diagnoses and Other Medical History: (briefly explain)

Asthma? Y or N What age was asthma diagnosed? _____ Ever hospitalized for asthma? Y or N
Ever in the ICU or intubated for asthma? Y or N

Food allergy or reactions? _____

Atopic Dermatitis, Eczema, or Hives? _____ When first noticed or diagnosed: _____
Where on the body did it begin? _____ Better or worse now? _____
Any noticeable triggers? _____

Any history of repeated infections? _____
Any hospitalizations or other illnesses? _____
Any surgeries or procedures done? _____

Patient Name: _____ DOB: _____

Allergic Rhinitis? Y or N or Don't Know Seasonal or Year-round? _____
Know of any triggers? _____

Predominant symptoms (circle): Sneezing Nasal Congestion Runny Nose Itchy/watery eyes
Itchy nose Frequent throat clearing Cough Snoring Colored Discharge Itchy ears
Swelling around eyes Throat drainage

Medications tried:

_____
_____

Any previous skin allergy testing? Y or N When? _____ Where? _____
Immunotherapy? Y or N When? _____ How long? _____ Better/worse? _____

Any insect allergy? _____

Any drug/antibiotic allergy? _____

Social History:
Any smoking exposure? _____ Caretaker Occupation: _____

Hobbies: _____

Lives with both parents? _____

What grade? (if in school) _____ Interest/play any sports? _____

Family History:
Any patient siblings, and how old?: _____

___Allergic Rhinitis ___Sinusitis ___Asthma ___Eczema ___Drug allergies ___Food allergies
___ Other: _____ Who has these? _____

Environmental:

How long in DFW? _____ Dwelling: House Apt/Duplex Mobile

Carpet inside home? Y or B In the bedroom? Y or N Live plants inside home? Y or N

Visible mold or water leak? Y or N

Any pets? _____ Sleep with pet in bedroom? Y or N

Reaction to any pets or animals? _____ Stuffed animals? Y or N

Physician Additional Notes:

_____

_____

_____

_____

_____

Patient Information Form

TEXAS REGIONAL ASTHMA & ALLERGY CTR

Appt Date/Time: Appt Provider: Chart #

Appt Comments:

Patient Information

First Name | Middle Initial | Last Name

Address | Address Line 2 | City | State | Zip Code

Email | Preferred Language | SSN | Date of Birth

Driver's License | State | Primary Phone | Phone Type | Secondary Phone | Phone Type

Gender
___ Male ___ Female

Marital Status
_____

Ethnicity
___ Hispanic/Latino ___ Not Hispanic/Latino ___ Declined

Race ___ White ___ Black or African American ___ American Indian or Alaskan Native ___ Asian ___ Native Hawaiian or Other Pacific Islander ___ Hispanic ___ Declined

Employer Name | Employer Phone

Emergency Contact Name | Emergency Contact Phone | Relationship to Patient

Referring Physician | Primary Care Physician

Insurance Information

Primary Insurance | Member # | Group #

Primary Insured Name | SSN | Relationship | Date of Birth | Gender
___ Male ___ Female

Secondary Insurance | Member # | Group #

Primary Insured Name | SSN | Relationship | Date of Birth | Gender
___ Male ___ Female

Financial Responsibility Information

Responsible Party Name | SSN | Relationship to Patient | Primary Phone

Address | Address Line 2 | City | State | Zip Code

Preferred Pharmacy

Pharmacy Name | Pharmacy Phone | Pharmacy Address

Patient/Guardian Signature

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I agree to pay for all services rendered whether or not paid by my insurance. If applicable, I agree to pay my co-payment and/or deductible & out-of-pocket at the time of service. I understand that I will be held fully responsible for any services deemed as non-covered or denied by my health insurance company.

I understand that I may make payment in the form of cash, check, or credit card (Mastercard, VISA, or Discover). I understand that my failure to make payment will result in future collection proceedings ($15 service fee will be applied). I understand that there is a $35.00 service fee on all returned checks.

I understand that I am welcome to contact the business office of Texas Regional Asthma & Allergy Center (TRAAC) to discuss any questions relating to my account.

I understand that TRAAC requires a 1 business day notification of cancellation for appointments & procedures. TRAACs policy is to charge $25.00 for no shows or late cancellations (subject to extenuating circumstances).

I certify I am 18 years of age/or the legal guardian of the patient. If I am the legal guardian/guarantor, I understand that I am financially responsible for the patient.

I assign insurance benefits and authorize treatments to be rendered by TRAAC.

I agree to release all such medical information that may be necessary to insure payment of my insurance claim(s).

I agree to notify TRAAC of any changes in my insurance status prior to treatment or I will be fully responsible for services rendered.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____

Patients Name:_____

Signature of Patient/Legal Guardian:_____

TRAAC Facsimile Authorization Form

I, the undersigned, authorize TRAAC to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below.

I may revoke this authorization by giving TRAAC five (5) days written notice. This revocation may be facsimile transmission: however a **written copy of the revocation must be mailed to TRAAC as well.**

Patient Name:_____

Signature of Patient or Parent of Minor: _____

Contact Information

Where can you be reached during business hours: ☐ Home ☐ Work ☐ Cell

May we contact you at home? ☐ YES ☐ NO
May we contact you at your place of business? ☐ YES ☐ NO

Leave Message:

Voicemail / Answering Machine ☐ YES ☐ NO
Family Member ☐ YES ☐ NO

May we contact you via email? ☐ YES ☐ NO Email address:_____
May we contact you via text message? (for appointment reminders only) ☐ YES ☐ NO

I hereby give permission to TRAAC to disclose any information related to my medical conditions to / with the following members (relatives, or close personal friends):

Name:_____ Relationship:_____
Name:_____ Relationship:_____

I do/do not wish to give permission for any family members, relatives, or close personal friends to have access to any information regarding my medical conditions:

☐ I do **NOT** wish to give permission ☐ I **DO** give permission to the above name(s)

Signature of Patient or Parent of Minor:_____ **Date:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of TEXAS REGIONAL ASTHMA & ALLERGY CENTER's "Notice of Privacy Practices". This notice describes how **TEXAS REGIONAL ASTHMA AND ALLERGY CENTER** may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient or Personal Representative) (Date)

_____

(Relationship to patient)

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice:

- Rene A. Leon, M.D., Richard A. Mayse, M.D., and Ali Shakouri, M.D., are owner/investors of Methodist Southlake Hospital, in Southlake, Texas.
- You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Methodist Southlake Hospital, in Southlake, Texas.
- You will **not** be treated differently by your physician if you choose to obtain healthcare services at a facility other than Methodist Southlake Hospital, in Southlake, Texas.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Methodist Southlake Hospital, in Southlake,Texas.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and understand that your physician has an ownership interest in Methodist Southlake Hospital, in Southlake, Texas.

_____
Signature of Patient

_____
Signature of Parent or Guardian
(if applicable)

_____
Print Name of Patient

_____
Print Name of Parent or Guardian
(if applicable)

Date: _____