Pediatric Lung, Allergy
and Sleep Specialists, P.C.

Allergy Asthma & Sleep Center
of Central Virginia

PATIENT INFORMATION **Patient Registration Form** (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____ - _____ - _____ ☐ Female ☐ Male Date of Birth _____ / _____ / _____

E-Mail Address _____

Referring Physician _____ Tel# _____ PCP _____ Tel# _____

Phone Numbers Home _____ ☐ Day ☐ Evening Work _____ ☐ Day ☐ Evening

Cellular _____ Pager _____

Address _____ City, State, ZIP (+4) _____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Patient Relationship to Emergency Contact _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ ☐ Female ☐ Male Date of Birth _____ / _____ / _____ E-Mail Address _____

Phone Numbers Home _____ ☐ Day ☐ Evening Work _____ ☐ Day ☐ Evening

Address _____ City, State, ZIP (+4) _____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

*** IT IS THE PATIENT'S RESPONSIBILITY TO GET ALL AUTHORIZATIONS FOR SERVICES ***

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Subscriber SS #: _____ ☐ Female ☐ Male

Insured Date of Birth _____ / _____ / _____ Insurance Company Address _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Insured Date of Birth _____ / _____ / _____ Insurance Company Address _____

I hereby authorize Pediatric Lung, Allergy and Sleep Specialists, P.C., dba Allergy Asthma & Sleep Center of Central Virginia, to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named Physician of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney for collection, that I will be responsible for attorney's fees and court cost and interest.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
SPOUSE /GUARDIAN SIGNATURE DATE

PLEASE COMPLETE BOTH SIDES

Pediatric Lung, Allergy and Sleep Specialists, P.C.
dba Allergy Asthma & Sleep Center of Central Virginia

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures that may be considered medically necessary
- Consent to allergy evaluation and testing. This may include allergy skin testing for foods, allergy to tree, grass or weed pollens, allergy to animal dander, mold spores or dust mites. This may also include a baseline test of lung function and a repeat lung function test after a medication is administered. I understand my account will be charged for these tests and my insurance company will be billed. I further understand that the final responsibility for the payment of the charges pertaining to my allergy and asthma evaluation is mine.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I, the undersigned, acknowledge that Pediatric Lung, Allergy and Sleep Specialists, P.C., dba Allergy Asthma & Sleep Center of Central Virginia will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Pediatric Lung, Allergy and Sleep Specialists, P.C., dba Allergy Asthma & Sleep Center of Central Virginia

ACKNOWLEDGEMENT

I,_____(patient), acknowledge that I have received a copy of Pediatric Lung, Allergy and Sleep Specialists, P.C.'s, dba Allergy Asthma & Sleep Center of Central Virginia (the practice's) Notice Regarding Privacy of Personal Health Information. I understand that if I have questions or complaints that I should contact the Privacy Official. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Legal Guardian if minor ***Date***

OK to leave message with relative? ☐ Yes ☐ No Phone #_____

OK to leave message on answering machine/voice mail? ☐ Yes ☐ No Phone #_____

_____ _____

Signature of Patient or Legal Guardian if minor ***Date***

Pediatric Lung, Allergy & Sleep Specialists, P.C.
1346 Alverser Drive
Midlothian, VA 23113
Tel. 804.897.1705
Fax. 804.897.1746

Allergy Asthma & Sleep Center of Central Virginia
3701 Boulevard - Suite H
Colonial Heights, VA 23834
Tel. 804.520.8932
Fax. 804.520.6748

Muhammad Rais, M.D., FAAP, FAAAAI

Patient Instruction/Consent Sheet for Allergy Skin Testing

Skin Test: Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:

Prick Method: The skin is pricked with a needle where a drop of allergen has already been placed.

Intradermal Method: This method consists of injecting small amounts of an allergen into the superficial layers of the skin.

Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

You will be tested to important (location) airborne allergens and possibly some foods. These include trees, grasses, weeds, molds, dust mites, and animal danders; and possibly some foods. The skin testing generally takes 45 minutes. Prick (also known as percutaneous) tests are usually performed on your back but may also be performed on your arms. Intradermal skin tests may be performed if the prick skin tests are negative and are performed on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy hive (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit. You may be scheduled for skin testing to antibiotics, caines, venoms, or other biological agents. The same guidelines apply.

DO NOT

1. No prescription or over the counter antihistamines should be used 4 to 5 days prior to scheduled skin testing. These include cold tablets, sinus tablets, hay fever medications, oral treatments for itchy skin, over the counter allergy medications; such as Actifed, Dimetapp, and Benadryl, as well as many others. If you have any questions whether or not you are using an antihistamine, please ask the nurse or the doctor. Some allergy eye medications have antihistaminic activity and will need to be discontinued prior to testing. Patients on new prescription antihistamines such as Claritin, Clarinex, Alavert, Allegra and Zyrtec should be off these medications for at least 5 days prior to testing. In some instances a longer period of time off these medications may be necessary.
2. Medications such as over the counter sleeping medications (e.g. Tylenol PM) and other prescribed drugs, such as amytriptyline hydrochloride (Elavil), hydroxyzine (Atarax), doxepin (Sinequan), and imipramine (Tofranil) have antihistaminic activity and should be discontinued at least 2 weeks prior to receiving skin test after consultation with your physician. Please make the doctor or nurse aware of the fact that you are taking these medications so that you may be advised as to how long prior to testing you should stop taking them.

YOU MAY

1. You may continue to use your intranasal allergy sprays such as Flonase, Rhinocort, Nasonex, Nasacort and Nasarel. Afrin and Sudafed may be used temporarily but not the day of testing.
2. Asthma inhalers (inhaled steroids and bronchodilators), leukotriene antagonists (e.g. Singular, Accolate) and oral theophylline (Theo-Dur, T-Phyl, Uniphyl, Theo-24, etc.) do not interfere with skin testing and should be used as prescribed.
3. Most drugs do not interfere with skin testing, but make certain that your physician and nurse know about every drug you are taking (bring a list if necessary).

Skin testing will be administered at this medical facility with a medical physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reaction to the allergy testing. Beta-blockers are medications that may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur, but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment.

We request that you do not bring small children with you when you are scheduled for skin testing unless they are accompanied by another adult who can sit with them in the reception room.

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours for which special allergens are prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours notice, due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized.

I have read and understand the patient information sheet on allergy skin testing. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing, and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient _____ Date signed _____

Parent or legal guardian*_____ Date signed _____
*as parent or legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.

Witness _____ Date signed _____

Allergy, Asthma, & Sleep Center

1346 Alverser Drive
Midlothian, VA 23112

Tel # (804)897-1705
Fax # (804)897-1746

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, he or she prevents another patient from receiving care. Pediatric Lung, Allergy, & Sleep Specialists, P.C. reserves the right to charge a fee of $50.00 for all appointments not cancelled with at least 24 hours notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Thank you for your understanding and cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

Cada vez que un paciente pierde una cita sin avisar con tiempo, el le roba la oportunidad a otro de recibir tratamiento. Pediatric Lung, Allergy, & Sleep Specialists, P.C. tiene el derecho de cobrar $50.00 a todo paciente que no avisa 24 horas antes de la cita que no va poder llegar.

Este cargo va ir a la cuenta del paciente. El seguro medico no lo paga, y usted lo tendrá que pagar antes de su próxima cita. Gracias por su cooperación y comprensión.

Con firmar abajo, usted reconoce que ha leído esta nota y comprende esta regla.

Patient Printed Name_____ Date _____

Patient Signature_____
(Parent/Guardian signature if patient is under 18)

Allergy, Asthma, & Sleep Center

EPWORTH SLEEPINESS SCALE:

Patient Name: _____ DOB: _____

Please fill in each box below "Chance of Dozing" in the table below. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation.

Favor de llenar cada espacio debajo de "Chance of Dozing" en la imagen. Cuanta posibilidad existe que usted se quede dormido en las situaciones nombradas abajo, en vez de solo sentirse cansado? Anote solo lo más reciente. Si no ha hecho estas cosas recientemente, intente anotar que sería el efecto. ***Use los números mostrados (de 0 a 3) para identificar como respondería a cada situación. (0 seria nunca me quedara dormido y 3 sería la más alta posibilidad de que me quede dormido.)***

SCALE:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
Sitting and Reading (*Sentarse a leer)*	
Watching TV (*Ver televisión*)	
Sitting , inactive, in a public place such as a theater or a meeting (*Sentarse inactivo en un lugar publico*)	
As a passenger in a car for an hour without a break (como un pasajero en un carro por mínimo una hora)	
Lying down resting in the afternoon when circumstances permit (*Acostado en la tarde a descansar*)	
Sitting and talking to someone (*Sentarse a platicar*)	
Sitting quietly after a lunch without alcohol (*Sentarse después del almuerzo sin beber alcohol)*	
In a car, while stopped for a few minutes in traffic (*En un carro detenido por minutos en trafico)*	
TOTAL SCORE (*Puntuación Total*)	

Patient Signature:_____ Date:_____
(Guardian signature if patient is under 18)