

**GENE A. DEVORA M.D., PHD, PA**  
*Allergy & Immunology*  
*Board Certified in Internal Medicine*

PRESBYTERIAN HOSPITAL OF PLANO  
Medical Office Building #2  
6300 West Parker Road, Suite 220  
Plano, Texas 75093  
Telephone: (972) 981-8215  
Fax: (972) 981-8038

**INSTRUCTIONS FOR DR. DEVORA'S NEW PATIENTS**

*Thank you for contacting our office for an appointment. In order for your appointment to go as smoothly as possible please read and follow the directions below.*

- ◆ *Please completely fill out the enclosed paperwork and bring it with you to your appointment.*
- ◆ *You may fax your paperwork to 972-981-8058 in advance, however you must also bring in the original paperwork with you to your appointment.*
- ◆ *Please arrive 30 minutes early for your appointment to allow time for parking, walking to our office, and checking in.*
- ◆ *If you are planning on filling out your new patient packet once you arrive in the office, then you must be here no later than 1 hour prior to your appointment time.*
- ◆ *Please bring your insurance card and driver's license with you to the appointment. We will need to make a copy to keep on file.*

*Your insurance may require referrals so make sure to review your policy and have a referral completed by your primary care physician if needed. As a courtesy to our patients, we attempt to determine your financial responsibility by verifying your insurance benefits. This is not a guarantee of the benefits. Your insurance policy is a contract between you and your insurance company and it is important that you understand the provisions. If you have any questions, please feel free to call your insurance company.*

*Should it be necessary to cancel your appointment, we do request 24 hours notice. You can reach the scheduling department anytime at 972-981-3617.*

*Thank you,  
Scheduling Department*

GENE A DEVORA, M.D.  
 ALLERGY AND IMMUNOLOGY  
 NEW PATIENT ALLERGY AND ASTHMA INFORMATION SHEET

Name \_\_\_\_\_ Date \_\_\_\_\_

Please circle the appropriate response. We will discuss your responses with you so do not elaborate on this form.

**Eyes:** Do your eyes:

Itch?	Y	N
Tear?	Y	N
Swell?	Y	N
Become Red?	Y	N

<b>Ears:</b> Do you have problems with your ears?	Y	N	Do you have frequent ear infections?	Y	N
If yes, do they: Pop Ring Itch					

<b>Nose:</b> Do you have problems with nasal drainage?	Y	N	Do you have problems with nasal congestion?	Y	N
Have you had sinus infections?	Y	N	Do you sneeze?	Y	N
Have you been told that you have nasal polyps?	Y	N			
Deviated septum?	Y	N			

<b>Mouth:</b> Do you have frequent sore throats?	Y	N
<b>and</b> Do you feel as if you have mucus		
<b>Throat</b> at the back of your throat?	Y	N

<b>Head:</b> Do you have frequent headaches?	Y	N	Are your headaches worse in the:		
If yes, are they:			Morning? Afternoon? Evening?		
Behind your eyes?	Y	N	Do you have congestion in your head?	Y	N
Under your eyes?	Y	N			
Back of your neck?	Y	N			
Side of your head?	Y	N			
Associated with sinus blockage?	Y	N			

<b>Chest:</b> Do you experience:			Have you ever been told that		
Tightness?	Y	N	you have asthma?	Y	N
Shortness of breath?	Y	N	Do you cough a lot?	Y	N
Pressure on your chest?	Y	N	If yes, do you cough up mucus?	Y	N
Wheezing?	Y	N			
Coughing?	Y	N	Color of mucus: _____		
Do you wheeze with colds or bronchitis?	Y	N			
If yes, is your wheeze seasonal?	Y	N			
If yes, which season(s)?	Y	N			
Winter? Spring? Summer?	Y	N			
Are your chest symptoms ever triggered by:					
Physical exertion?	Y	N			
Strong emotions?	Y	N			
Dust/Mold?	Y	N			
Asprin?	Y	N			

<b>Skin:</b> Have you ever had:		
Eczema?	Y	N
Hives?	Y	N
Rash?	Y	N
Swelling of your skin?	Y	N

GENE A. DEVORA, M.D.  
 NEW PATIENT ALLERGY AND ASTHMA INFORMATION SHEET  
 PAGE 2

Name \_\_\_\_\_ Date \_\_\_\_\_

**Previous Evaluation/Treatment:**

Have you had sinus x-rays?	Y	N	If yes, date _____
Have you ever been skin tested?	Y	N	If yes, date _____
Have you ever taken allergy shots?	Y	N	If yes, date started _____ date stopped _____
Have you ever had a chest x-ray?	Y	N	If yes, date _____

**Environmental:**

Are your symptoms seasonal?	Y	N	If yes, which season (s): Summer? Fall? Winter? Spring?			
Are your symptoms worse:						
Indoors?	Y	N	Around mowed grass?	Y	N	
Outdoors?	Y	N	Around dust?	Y	N	
At Work / School?	Y	N	Around flowering plants?	Y	N	
Around cleaning agents / sprays?	Y	N	Around trees?	Y	N	
Around animals?	Y	N	Around vehicle exhaust?	Y	N	
How long have you lived in the Dallas area? _____			How old is your present house / apt.? _____			
Do you use ceiling fans in your house?	Y	N	Do you have a humidifier?	Y	N	
Is your pillow filled with: Foam? Feathers?			Is your pillow and /or mattress covered in plastic? Y N			
Is your bedroom carpeted?	Y	N	If yes, what kind? _____			
Do you have any pets?	Y	N				
Are the pets: Inside? Outside? Both?						
Do you have plants in the house?	Y	N				

**Medical History**

Which symptom(s) bother you the most? \_\_\_\_\_

How long have your symptoms bothered you? \_\_\_\_\_

Are you allergic to any foods?	Y	N	Are you sensitive / allergic to any drugs?	Y	N
If yes, please list:			If yes, please list:		
Food	Reaction:		Medicine:	Reaction:	
_____	_____		_____	_____	
_____	_____		_____	_____	
_____	_____		_____	_____	

Are you sensitive / allergic to latex? Y N

Have you had a reaction to an insect sting?	Y	N	If yes, what insect? _____
Circle the type of reaction:		Swelling at the bite site	Pain
		Wheezing	Shortness of breath
		Redness	Stuffy Nose
		Hives	Throat closing

Have you ever had an injury or surgery of the nose? Y N

Do any family members suffer from:	Allergies?	Y	N
	Hay fever?	Y	N
	Asthma?	Y	N

**GENE A. DEVORA, M.D.**  
**Allergy and Immunology**

**PATIENT MEDICAL HISTORY**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

CHIEF COMPLAINT \_\_\_\_\_

FAMILY HISTORY	YES	NO
Has any relative had Cancer of breasts, female organs, colon, melanoma	(    )	(    )
Tuberculosis (in the past 5 years)	(    )	(    )
Diabetes	(    )	(    )
High blood pressure	(    )	(    )
Kidney trouble (Other than kidney stones)	(    )	(    )
Heart disease	(    )	(    )
Anesthesia complication	(    )	(    )

**PERSONAL HISTORY**

\_\_\_\_\_ Weight \_\_\_\_\_ Height  
Exercise: Do you exercise at least 20 minutes, 3 times a week? YES (    ) NO (    )  
Alcoholic Beverages: \_\_\_\_\_ Never \_\_\_\_\_ Occasionally \_\_\_\_\_ Moderately \_\_\_\_\_ Daily  
Do you smoke: YES (    ) NO (    )  
  If yes, # of packs per day \_\_\_\_\_  
  If you have quit, how long has it been? \_\_\_\_\_  
Have you used, previously used or had problems with:  
  \_\_\_\_\_ Marijuana \_\_\_\_\_ Heroin \_\_\_\_\_ Cocaine \_\_\_\_\_ Other recreational drugs

**MEDICAL HISTORY**

Have you ever had	YES	NO		YES	NO
Asthma or breathing problems	(    )	(    )	Colon trouble or bowel disorder	(    )	(    )
Anemia (longer than 3 months)	(    )	(    )	Kidney Trouble	(    )	(    )
Tuberculosis	(    )	(    )	Venereal disease	(    )	(    )
High blood pressure	(    )	(    )	Varicose veins or Phlebitis	(    )	(    )
Heart disease or murmur	(    )	(    )	Bleeding Disorders	(    )	(    )
Diabetes	(    )	(    )	Seizures, loss of consciousness	(    )	(    )
Depression	(    )	(    )	Visual disturbance	(    )	(    )
Thyroid disorder	(    )	(    )	Treatment of nervous disorder	(    )	(    )
Ulcer or Stomach problems	(    )	(    )	Cancer	(    )	(    )
Hepatitis, jaundice	(    )	(    )	Blood transfusions	(    )	(    )
Hospitalization for psychiatric reasons	(    )	(    )	Alcohol Abuse	(    )	(    )
Other _____			Drug Abuse	(    )	(    )

Please explain "YES" answers: \_\_\_\_\_

**IMMUNIZATIONS**

Have you had a tetanus shot in the last 10 years? YES (    ), on this date \_\_\_\_\_ NO (    )  
Have you had a pneumonia shot in the last 10 years (only age 50 & over)? YES (    ), on this date \_\_\_\_\_ NO (    )  
Have you had any other immunizations in the past? \_\_\_\_\_

**OTHER**

Last Dental Exam \_\_\_\_\_ Dentist Name \_\_\_\_\_  
Last Eye Exam \_\_\_\_\_ Eye Doctor Name \_\_\_\_\_

**SURGERIES (Include dates)** \_\_\_\_\_

**MEDICATIONS:** Please list all medication you are currently taking (include dosage):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE: \_\_\_\_\_ PATIENT SIGNATURE: \_\_\_\_\_

**GENE A. DEVORA, M.D.**  
**Allergy & Immunology**  
**PATIENT INFORMATION**

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ PAGER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ FAX # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

**EMERGENCY INFORMATION**

SPOUSE \_\_\_\_\_ SPOUSE WORK PHONE \_\_\_\_\_

RELATIVE \_\_\_\_\_ RELATIVE HOME PHONE \_\_\_\_\_

FRIEND \_\_\_\_\_ FRIEND HOME PHONE \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

\_\_\_\_\_ PRIVATE PAY (Cash)    \_\_\_\_\_ PPO    \_\_\_\_\_ HMO    \_\_\_\_\_ MEDICARE    \_\_\_\_\_ OTHER

INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

INSURED'S SSN \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_

HOW LONG AT ABOVE EMPLOYER \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

INSURED'S SSN \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_

**PATIENT / RESPONSIBLE PARTY'S AUTHORIZATION**

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO PROCESS CLAIM.

I REQUEST THAT PAYMENT OF MEDICAL BENEFITS BE MADE TO DR. LESLIE WEISBERG AND I UNDERSTAND THAT THIS IS AUTOMATIC IN CASE OF HOSPITALIZATION. THIS ASSIGNMENT OF BENEFITS WILL REMAIN EFFECTIVE UNTIL REVOKED BY ME IN WRITING.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**GENE A. DEVORA, M.D.**  
**Allergy and Immunology**  
**PAYMENT POLICY**

1. We will file insurance for our PPO, HMO and other managed care patients. However, all managed care copayment and/or deductible and coinsurance amounts are due at the time of the service. Any disallowed/uncovered amounts are due from the patient. It is your responsibility to make sure that Leslie A. Weisberg, M.D. is in your managed care network. There will be a \$15.00 fee added to your account if the copay coinsurance is not paid at the time of the service.
2. Patients who do not cancel or reschedule their appointment at least 24 business hours prior to their scheduled visit will be charged a fee of **\$25.00**. Also, this fee applies to any patients that do not show up for their scheduled appointment. This office will make reasonable attempts to confirm appointments one to two days in advance of the appointment date. Excessive no shows and/or cancellations could be grounds for termination from Plano Internal Medicine Associates.
3. There will be a twenty-five dollar (\$25) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount. Payments will be expected in the forms of cash, money order, Visa or Master Card. If payment is not received by the due date indicated on the bill, then your information will be turned over to the Collin County District Attorney. After receiving a returned check we will no longer accept check payments on any future visits not to exceed five years.
4. For all account balances in excess of 90 days a collection fee of \$50.00 will be added to the balance (even if payment delay is due to the insurance company) and the account will be turned over to our collection company. It is ultimately the patient's responsibility to make sure the doctor received payment for service rendered.
5. We accept assignment and will file insurance for our Medicare patients. However, any calendar year deductible amounts (to the extent of the visit amount) are due at the time of service. We will also file secondary insurance after payment from Medicare. If there is no secondary insurance, patient will be billed for any remaining balance.
6. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims, reductions or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. We will attempt to verify coverage, although that is not a guarantee of payment until your insurance has processed the claim.
7. Personification of Hospital – we must be notified within twenty four (24) hours of any hospital admit so that we may precertify your hospital visit/stay. Failure to do this may result in reduction of benefits. We will not be responsible for any reduction of benefits if this is not done.
8. If any patient is owed a refund, all claims must be processed and paid in full before overpayment is refunded.
9. All patients are required to give their Social Security No. **No Exceptions**. If the insurance policy is through someone other than the patient we will need their Social Security No. as well. This is to ensure payment for services that are rendered by PIMA.

**REFERRAL AUTHORIZATION**

When referred, it is the patient's responsibility to verify that the physician or facility is in their insurance network. If you are a patient who requires a referral to see Dr. Weisberg, you must have your referral with you at the time of your appointment, or it must be faxed to our office before you arrive to see the doctor. Any patient without a referral must be rescheduled until the referral is received in our office, or the patient must pay for their visit in full at the time of the appointment. No exceptions will be made.

**AUTHORIZATION**

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits and hospital stays to Leslie A. Weisberg, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Plano Internal Medicine Associates  
6300 West Parker Road  
Suite 220  
Plano, TX 75093  
(972) 981-8215**

## **CANCELLATION / NO SHOW POLICY**

Patients who do not cancel or reschedule their appointment at least 24 business hours prior to their scheduled visit may be charged a fee of **\$25.00**. Also, this fee applies to any patients that do not show up for their scheduled appointment. The office will make reasonable attempts to confirm appointments one to two days in advance of the appointment date.

**It remains the patient's responsibility to keep or reschedule appointments in compliance with the above policy. *Exceptions will be made for medical or family emergencies.* Please note that insurance companies cannot be billed for missed sessions.**

I have read, understand, and agree to comply with the above policy.

---

Patient Name (Print)

---

Patient Signature

---

Date