

FRANCISCO J. CANO M.D. PC

Diplomat of the American Board of Allergy & Immunology
Pediatric & Adult Asthma, Allergy, & Immunology

59 West Main Street
Greenville, PA 16125

(724) 589-4301

(888) 588-7531

Fax (724) 588-5914

Patient Name _____ **Office** _____
Appointment Date _____ **Appt Time** _____

Welcome to the Allergy Practice!

For us to serve you at your first appointment, please read the following information:

1. Please complete the enclosed forms prior to your appointment and bring the completed forms and your insurance card with you to your scheduled appointment.
2. If your insurance requires a co-payment, it will need to be paid the day of your appointment.
3. If your insurance requires referrals, we will not be able to see you without one. Please request this from your Primary Care Physician prior to your appointment.
4. **Antihistamines interfere with allergy testing and need to be stopped one week prior to your appointment to be tested. Examples of antihistamines include: Any form of Claritin, Clarinex, Allegra, Zyrtec, Alavert, Benadryl, or any Over the Counter Antihistamine.** We understand that some patients (example: someone with hives or a rash) may not be able to stop taking their antihistamine without getting sick. If you are currently taking an antihistamine and do not think you can stop it for one week, call our office. Also, if you have questions about other medications you are taking, please contact our office and we will discuss them. **DO NOT STOP TAKING MEDICATIONS FOR ASTHMA OR ANY OTHER HEALTH PROBLEM!!!! IT IS NECESSARY AND COULD MAKE YOU SICK!!!!**
5. Please allow 1 to 1 ½ hours for your appointment. We usually do allergy testing on the first visit. If we do allergy testing at your appointment, you can expect the results of your tests before you leave.
6. Everyone at Dr. Cano's office is committed to providing quality care. If you have any questions or concerns, please do not hesitate to call our office.

Thank You,

Francisco J Cano, M.D. PC & Staff

Skin Testing: What to expect

Skin testing is the method we use to evaluate our allergy patients. It involves a prick test first and then an intradermal test.

The prick test is done on the patients back and involves the use of “tiny plastic prickers”. Each “pricker” is dipped into a specific allergen and then we prick the patients back. Results are available in less than 15 minutes. We prefer this method because it is most reliable and provides minimal discomfort to the patient.

Following the prick test it is often necessary to perform an intradermal test. This test is done on the forearm and involves tiny intradermal injections of specific allergens under the skin using a needle. Again, results are available within 15 minutes.

For patients under the age of 5: Allergy testing is usually very limited. We only do as many tests as Dr. Cano and the parents feel necessary.

Blood testing is rarely ordered in our office. It is very expensive, not as reliable as skin testing, is susceptible to interpretation errors and it takes up to two weeks to get results back.

**WHEN YOU COME FOR YOUR
APPOINTMENT PLEASE BRING:**

PATIENT INSURANCE CARD

FULL NAME OF THE PERSON WHO CARRIES THE INSURANCE

**DATE OF BIRTH, SOCIAL SECURITY NUMBER, INSURANCE ID
AND GROUP NUMBER OF THE PERSON WHO CARRIES THE
INSURANCE**

**RECENT PHOTO ID: DRIVERS LICENSE, SCHOOL PICTURE, OR
WORK ID (DUE TO INCREASED INSURANCE FRAUD)**

PRIMARY CARE PHYSICIAN NAME AND PHONE NUMBER

REFERRING PHYSICIAN NAME AND PHONE NUMBER

**PATIENT PHARMACY OF CHOICE: NAME, PHONE#, FAX#, AND
ADDRESS**

**IF YOU DO NOT BRING YOUR INSURANCE INFORMATION
PAYMENT WILL BE EXPECTED**

PLEASE REVIEW AND SIGN OUR FINANCIAL POLICY

Have you experienced any of the following symptoms? If so check the appropriate box.

Constitutional:	ENMT cont.	Genitourinary:	Endocrine:
Weight Loss	Stiffness	Blood	Cold intolerance
Fever	Throat clearing	Incontinence	Frequent eating
Decrease energy	Bad breath	Infections	Heat intolerance
Eyes:	Hoarseness	Joints:	Excess drinking
Watering	Voice change	Stiffness	Hematology:
Itching	Heart:	Swelling	Enlarged lymph nodes
Redness	Chest Pain	Skin:	Lymph nodes pain
Swelling	Murmurs	Eczema	Allergy/Imm:
ENMT:	Palpitations	Hives	Latex Reactions
Infections	Respiratory:	Itchy skin	Drug reactions
Hearing Loss	Cough	Breast:	Bee Allergies
Ringing	Difficulty breathing	Breast problems	Prior Allergy Shots
Tubes	Wheezing	Neurological:	
Runny nose	GI:	Dizziness	
Nasal discharge	Abdominal pain	Fainting	
Postnasal drip	Constipation	Headaches	
Sneezing	Diarrhea	Mood:	
Frequent Colds	Heartburn	Poor concentration	
Itchy nose	Indigestion	Loss of interest	
Mouth Breathing	Vomiting	Poor sleep	
Sinusitis			
Snoring			

FRANCISCO CANO, M.D., P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

DATE _____

NAME _____ DATE OF BIRTH _____ MALE _____ FEMALE _____

MAILING ADDRESS _____ APT.# _____ MARITAL SINGLE _____ MARRIED _____
STATUS: DIVORCED _____ WIDOW _____

CITY _____ STATE _____ ZIP CODE _____ SOC.SEC. # _____

HOME PHONE (____) _____ - _____ OCCUPATION _____ EMPLOYER _____

WORK PHONE (____) _____ - _____ EMAIL ADDRESS _____

SPOUSE INFORMATION

NAME _____ DATE OF BIRTH _____ PATIENT HERE? YES ___ NO ___

SOC. SEC. # _____ WORK PHONE# (____) _____ - _____

FINANCIAL RESPONSIBILITY

RESPONSIBLE PARTY _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ - _____ MARITAL STATUS S ___ M ___ D ___ W ___ SOC. SEC. # _____

INSURANCE INFORMATION

PLEASE PRESENT YOUR CARD TO RECEPTIONIST TO BE COPIED

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ EMPLOYER _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

NAME OF INSURANCE CO _____ ID# _____ GROUP# _____

PLEASE KEEP US INFORMED OF ANY INSURANCE CHANGES

SECONDARY INSURANCE PLAN

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ EMPLOYER _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF INSURANCE CO _____ ID# _____ GROUP# _____

NAME OF REFERRING PHYSICIAN _____ PHONE#(____) _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF PAYMENT

I hereby authorize Francisco Cano M.D., P.C. to release any medical information required in the course of examination and treatment and permit payment directly to Francisco Cano M.D., P.C. any benefits due for the services rendered to me and/or my dependents. I recognize and accept responsibility for service rendered regardless of my insurance coverage. This includes but is not limited to co-insurance, co-payments, deductibles and non-covered services.

SIGNATURE _____ DATE _____

Financial Policy

Francisco Cano, M.D., P.C.

In order to keep a strong trust relationship with our patients and render the best medical care, we must have an understanding of the responsibility of the patient:

1. All co-pays will be paid at the time of service. We accept cash, checks, Visa and Master Card.
2. You will be expected to present your insurance card and the plan holder information at every visit **including shots.**
3. When unable to keep an appointment with Dr. Cano you must call 24 hours in advance. New patients who fail to call or keep their first two appointments will be charged for the second missed appointment. A third will not be scheduled.
4. All referrals from primary care physicians are the patient's responsibility. If a referral has expired and you do not have a new one, services may not be rendered.
5. If you have a large deductible, as in a health savings plan, please make us aware of this and arrange for deductibles to be paid in a timely fashion.
6. If your insurance is carried through a Pennsylvania State Employee, you will need to call this to our attention. This is because allergy serum is not covered under the medical portion of the plan. Serum is billed to Medco, the plan pharmacy, which requires their specific claim form and the signature of the plan holder. This payment will be sent to you. In order to properly credit your account, please endorse the check and include Medco's explanation of benefit.
7. All patients without active healthcare insurance will be expected to pay when services is rendered. Communication is vital. Please do not allow a situation of embarrassment over finances to develop.

Print Patient Name _____ Patient D.O.B _____

Responsible Party Signature _____

I hereby authorize Francisco Cano M.D.,P.C. to release any medical information required in the course of my care to my insurance carrier as needed for payment. I also permit payment to be made directly to Francisco Cano M.D. for payment from insurance for services rendered to me and/or my dependents. I recognize and accept responsibility for service rendered regardless of my insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible, and non-covered services.

Responsible Party Signature _____