



Patient Registration Form

Personal Information

Name (Last, First, M.I.) _____ Date _____

Birthdate _____ Soc. Security # _____ - _____ - _____

Male Female Single Married Divorced Widowed

Race Ethnicity American Indian Asian African American Pacific Islander Caucasian Other Decline Hispanic or Latino Not Hispanic or Latino Unknown

Mailing Address _____

City, State, Zip _____

Employer _____ Occupation _____

Patient Employment Status: Employed FT Retired Student

Primary Care Physician _____ Phone# _____

Referred By _____

Contact Information

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

E-Mail _____ Preferred Method of Communication _____

In the event of an emergency, who do you give us authorization to contact?

Name _____ Relationship _____ Contact # _____

Do you have: Living Will: Yes No Medical Power of Attorney: Yes No

***If YES, we need copy on file.

Insurance Information

Primary Insurance Information : Additional Insurance: Insurance Company Name of Insured Relationship to patient Insured's Birthday Soc. Sec. # Policy Holders Employer:



Authorizations

Authorization for Release of Information

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to East Valley Center for Pulmonary & Sleep Disorders, all insurance benefits payable to me for the services rendered by this group. **I understand that I am responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Office Policies:

1. \$25.00 FEE for No Shows and Late Cancellations (canceling with less than 24 hour notice): To avoid this fee, please call and cancel or reschedule all appointments within 24 hours of your scheduled appointment. If after hours, please call our office number and leave a message with our answering service.
2. Managed Care Plans (HMO, PPO, POS)
It is the patient's responsibility to verify our physician's participation to their health plan prior to making an appointment. If your plan requires a referral, you need to contact the Referral coordinator at your Primary care Physicians office. If failed to do so, the visit may NOT be authorized by your insurance carrier and you will be asked to pay for services rendered.
3. It is the patient's responsibility to inform the billing department of any changes in insurance coverage immediately. I understand that I may be responsible for charges if correct insurance is not provided and billed timely.

Financial Policy Acknowledgement

I have read and understood the above financial policies for East Valley Center for Pulmonary & Sleep Disorders and understand that full payment of my office co-pay is due at the time of service. I understand that if I do not have insurance coverage, the full payment for services is due at the time the services are rendered unless payment arrangements have been made prior to my appointment.

Authorization to Obtain Past Medical Information

I give permission to East Valley Center for Pulmonary & Sleep Disorders to obtain all of my past medical information for continuity of care.

PBM (Pharmacy Benefit Management)/Pharmacy Drug History

I give permission to East Valley Center for Pulmonary & Sleep Disorders to obtain all of my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Responsible Party Signature _____ Date _____

Printed Name _____



Consent to Use and Disclose Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected health information will be used by East Valley Center for Pulmonary & Sleep Disorders (EVP) and released to others for the purpose of treatment, obtaining payment, or supporting the day-today health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. EVP may or may not agree to restrict the use or disclosure of your protected health information. If EVP agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

East Valley Center for Pulmonary & Sleep Disorders reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to East Valley Center for Pulmonary & Sleep Disorders to use and disclose my health information in accordance with it.

(Name of Patient, Print or Type)

(Signature of Patient)

(Date)



Authorization to Disclose Information to Family Members/Friends

I, the undersigned, authorize East Valley Center for Pulmonary & Sleep Disorders to disclose all of my medical information to the following individuals:

Spouse: YES NO Name: _____ DOB: _____
Children YES NO Name: _____ DOB: _____
 YES NO Name: _____ DOB: _____
 YES NO Name: _____ DOB: _____
Other YES NO Name: _____ DOB: _____

HIPAA Message Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

- Home Telephone
- Cellphone number
- Okay to leave a message with detailed info
- Okay to mail to my home address
- Leave a message with a call-back number only
- Okay to mail to my work address
- Okay to fax to this number : _____
- Work Telephone
- Leave a message with a call-back number only

Patient/Guardian Signature _____

Date _____

Name (Printed) _____ Date of Birth ___ / ___ / _____

FOR OFFICE USE ONLY:

Written acknowledgment of receipt of our Notice of Privacy Practices but could not due to:

Individual refused to sign this document
 Care provided was emergent
 Other: _____
Employee Name: _____ Date: _____



Welcome to East Valley Center for Pulmonary & Sleep Disorders. In order to insure your best care, it is important that you take the time to complete this medical questionnaire thoroughly. Please list your name and today's date in the space provided at the top of each page.

Name _____ Date of Birth _____

Who referred you? _____

What is your main complaint today?

How long have you had this problem? _____

Past Medical History:

Past Illnesses: *(Please check any illnesses you've had)*

- Rheumatic Fever
- Kidney Disease
- Liver Disease
- Anemia
- Stroke
- Blood Clots
- Cancer
- Bronchitis

- Allergies/Hay Fever
- Emphysema/COPD
- Sleep Apnea
- Heart Attack
- High Blood Pressure
- Diabetes
- Tuberculosis
- Pneumonia
- Asthma
- Other: _____

When was your last TB skin test? _____

Immunizations:

- Pneumonia (Date) _____
- Flu (Date) _____

Have you had a blood transfusion? Y / N
If so, When? _____

Name _____ Date of Birth _____

Surgery:

Name of Surgery	Year

Social History:

History of tobacco use: (Circle Type that Applies)

Current Smoker: YES NO
Former Smoker: YES NO
Cigarettes Cigars Pipe Chewing Tobacco
Age Started? _____ Age Quit: _____
I am presently smoking _____ per day.
I previously smoked _____ per day.

History of Alcohol Use:

Do you consume alcohol? Y / N
If so, how many drinks per week?

Caffeine Use:

Do you consume caffeine? Y / N
If so, how many drinks per day?

Illicit Drug Use:

Do you use illegal drugs? Y / N
If so, what type and how often?

Children:

Number of children: _____
Any Medical problems?

Environmental History:

Have you ever been exposed to any harmful substances? (Eg: Asbestos)

Name of Harmful Substance	# of years

Occupational Information:

List all Occupations
(Former Occupation if Retired):

Occupation

Name _____ Date of Birth _____

Family History:

Check any diseases that a blood relative may have had:

- Heart Disease
- Allergies
- Congenital Disease
- Nervous Illness
- Thyroid Disease
- TB
- Cancer
- Diabetes
- High Blood Pressure
- Other: _____

Family Member	Living	Deceased	Age/Age at Death	Health Cond. or Cause of Death
Father				
Mother				
Spouse				

Siblings	Age/Age at Death	Current Health Cond. or Cause of Death

Name _____ Date of Birth _____

System Review: Please check all that apply

ENT:

- _____ Difficulty hearing
- _____ Earache
- _____ Nasal drainage
- _____ Nosebleeds
- _____ Persistent hoarseness
- _____ Sore throats
- _____ Sinus Infections

Eyes:

- _____ Wear glasses
- _____ Impaired vision
- _____ Irritation of eyes
- _____ Watering of eyes

Respiratory:

- _____ Shortness of breath
- _____ Wheezing
- _____ Sputum Production
- _____ Cough up blood
- _____ Daily cough
- _____ Frequent colds

Cardiac:

- _____ Chest pain
- _____ Irregular heartbeat
- _____ High blood pressure
- _____ Leg swelling
- _____ Palpitation
- _____ SOB while walking

Gastrointestinal:

- _____ Poor appetite
- _____ Difficulty swallowing
- _____ Nausea or vomiting
- _____ Heartburn
- _____ Abdominal pain
- _____ Constipation
- _____ Bloody/Black stools
- _____ Diarrhea

Genitourinary:

- _____ Getting up more than once a night to urinate
- _____ Difficulty urinating
- _____ Trouble emptying bladder
- _____ Blood in urine

Gynecological: (Females Only)

- _____ Menopause
- _____ Hormonal replacement
- _____ Birth control pills

Neurological:

- _____ Bad headaches
- _____ Blackout spells
- _____ Seizures
- _____ Numbness or tingling
- _____ Poor balance
- _____ Weakness or paralysis

Psychiatric:

- _____ Anxiety/Panic attacks
- _____ Feeling depressed

Endocrine:

- _____ Hormonal problems
- _____ Bulging eyes

Skin:

- _____ Pain
- _____ Itching
- _____ Growth/lesion
- _____ Skin cancer Where? _____

Immune system:

- _____ Multiple infections
- _____ Immune deficiency
- _____ Seasonal allergies

General:

- _____ Fatigue
- _____ Fever or sweats
- _____ Weight loss? Amount _____
- _____ Weight gain? Amount _____

Sleep Habits:

- _____ Daytime sleepiness
- _____ Snoring
- _____ Witness apnea (someone has reported you stop breathing during sleep)
- _____ Morning headaches
- _____ Restless sleep
- _____ Leg movements
- _____ Difficulty sleeping



Seyed A. Javadpoor, M.D.
Lina A. Anthony, M.D.
Alhassan Badahman, M.D.
Arturo "Happy" Castro D.O.
Sankalp Choudhri, M.D.
Dashant S. Kavathia, M.D.
Salman Sheikh, M.D.

STOP-BANG Obstructive Sleep Apnea Screening Questionnaire

Patient Name: _____ DOB: _____

Today's Date: _____

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)
Yes No
2. Do you often feel tired, fatigued, or sleepy during the daytime?
Yes No
3. Has anyone observed you stop breathing during your sleep?
Yes No
4. Do you have or are you being treated for high blood pressure?
Yes No
5. BMI more than 35 kg/M²?
Yes No
6. Age over 50 years old?
Yes No
7. Neck circumference greater than 40cm (17"-Male; 16"-Female)?
Yes No
8. Gender male?
Yes No

Score _____ Number of questions patient answered "yes"

***High risk of OSA: answering yes to ≥ 3 or more questions.

**Low risk of OSA: answering yes to < 3 questions

