East Valley
Center for Pulmonary & Sleep Disorders

Patient Registration Form

Personal Information

Name (Last, First, M.I.)_____Date_____

Birthdate _____ Soc. Security # _____ - _____ - _____

□ Male □ Female □ Single □ Married □ Divorced □ Widowed

Race □ American Indian □ Asian □ African American □ Pacific Islander □ Caucasian □ Other
Ethnicity □ 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 :

Insurance Company _____

Name of Insured _____

Relationship to patient _____

Insured's Birthday _____

Soc. Sec. # _____-_____- _____

Policy Holders Employer: _____

Additional Insurance:

Insurance Company _____

Name of Insured _____

Relationship to patient _____

Insured's Birthday _____

Soc. Sec. # _____-_____- _____

Policy Holders Employer:_____

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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 _____

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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 of 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)

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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: _____

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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

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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

Current Medication List:

Name of Medication	Dosage	How often do you take it	Date Started

Allergies to Medication:

Please list any allergies to medication:

Medication	Type of Reaction

Pharmacy Name:_____

Pharmacy Phone Number: _____

Patient/Guardian Signature _____

Date _____

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