RESPIRATORY AND SLEEP DISORDERS SPECIALISTS

Today's Date: _____

New Patient Information

Last Name_____ First Name _____ Middle _____

Date of Birth _____ Social Security No _____ Male / Female (circle)

Street Address _____

City/State/Zip _____ Student? YES NO

Occupation _____ Marital Status _____

Cell Phone (preferred) _____ Alternate Phone (cell/work/home) _____

Email address _____

The HIPAA privacy rule gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual also has the right to request confidential communication of that a communication of PHI be made by alternative means, such as sending correspondence to individual's office instead of the individual's home. **I wish to be contacted in the following manner (check all that apply):**

☐ Cell Phone ☐ Work Phone ☐ Home Phone ☐ Mail address: _____

EMERGENCY CONTACT & MEDICAL RECORD ACCESS

In addition to being my emergency contact(s), I authorize RSDS to communicate with the individual(s) listed below regarding any medical and/or financial issues. The privacy rule also allows for a patient to allow certain people to have access to their records, per patient's written allowance. Please specify which contacts are allowed this access to your medical records.

Name	Relationship	Contact Cell #	Allow Record Access?
			Yes or No
			Yes or No
			Yes or No

RESPONSIBLE PARTY/GUARANTOR

If same as patient, skip this section

Last Name_____ First Name _____ Middle _____

Date of Birth _____ Social Security No _____ Male / Female (circle)

Street Address _____

City/State/Zip _____ Student? YES NO

Occupation _____ Marital Status _____

Cell Phone (preferred) _____ Alternate Phone (cell/work/home) _____

Email address _____

Patient Name: _____

RESPIRATORY AND SLEEP DISORDERS SPECIALISTS

REFERRAL / CONTINUITY OF CARE

REFERRING DOCTOR _____ **PRIMARY CARE DOCTOR** _____

Other Specialists Involved in your Care (List name and specialty – Cardiologist, Oncologist, etc.)	

INSURANCE INFORMATION		
	Primary Insurance	Secondary Insurance
Insurance Name		
Name of Policy Holder		
SSN of Policy Holder		
Relation to Patient		
Employer		
Policy or ID Number		
Group Number		
PHARMACY INFORMATION		
Local Pharmacy	Name:	Phone #
Mail Order Pharmacy	Name:	Phone #

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above & assign directly to RSDS all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the use of this signature of all insurance submissions. I have received, read, & understand all documents given to me in regard to HIPAA rights as a patient. If patient is a minor, _____(parent/guardian) consent to minor's evaluation and treatment.

Signature: _____ Date: _____

Parent/Guardian signature if patient is a minor: _____Date: _____

Patient Name: _____

RESPIRATORY AND SLEEP DISORDERS SPECIALISTS

PATIENT HISTORY

1 Why are you here to see the doctor today?

_____

_____

_____

2 Do you currently have or suffer from any of the following

☐ Shortness of breath	COPD / Emphysema / Bronchitis	☐ Asthma
☐ Cough	☐ Lung Cancer	☐ Pulmonary Embolism/DVT
☐ Coughing up blood	☐ Pulmonary Nodule	☐ Bronchiectasis or MAC/MAI
☐ Snoring/Sleep Apnea	☐ Other cancer _____	☐ Unexplained weight loss
☐ Insomnia	☐ Chest Pain or pressure	☐ Fever or chills
☐ Other Sleep Issue	☐ Heart disease	☐ Tuberculosis or +PPD
☐ GERD/Reflux	☐ Heart failure	☐ Allergic Rhinitis
☐ Hoarseness	☐ Arrhythmia	☐ Rash

Other: (please list any and all medical problems you have that are not listed above)

_____

_____

_____

3 What surgeries or operations have you had and when?

_____

_____

4 Have you had Imaging (CXR, CT Scan, Echocardiogram, etc) done? If yes, where and when?

_____

_____

5 Have you been hospitalized recently or seen in an ED or Urgent Care, if so where and when?

_____

_____

6 Do you suffer from snoring, waking up gasping, witnessed choking episodes, excessive sleepiness and/or fatigue? YES or NO

7 Do you suffer from insomnia, or an inability to fall asleep or stay asleep? YES or NO

8 Do you have uncontrollable sleep attacks or brief episodes of loss of muscle tone and function? YES or NO

9 Any other unwanted behaviors during sleep? _____

Patient Name _____

RESPIRATORY AND SLEEP DISORDERS SPECIALISTS

10 **How likely are you to fall asleep in the following situations?**				
Sitting and reading	___ Never	___ Slight	___Moderate	___High
Watching television	___ Never	___ Slight	___Moderate	___High
Sitting inactive in a public place	___ Never	___ Slight	___Moderate	___High
As a passenger in a car for more than 1 hour	___ Never	___ Slight	___Moderate	___High
Lying down to rest in the afternoon	___ Never	___ Slight	___Moderate	___High
Sitting and talking to someone	___ Never	___ Slight	___Moderate	___High
Sitting quietly after lunch	___ Never	___ Slight	___Moderate	___High
In a car stopped at a traffic light	___ Never	___ Slight	___Moderate	___High

11 **Vaccine Status**	
Flu Vaccine? **Yes No Date**:	Pneumonia Vaccine? **Yes No Date**:
COVID Vaccine? **Yes No Date**:	If yes to above: Prevnar 13 or Pneumovax 23?
12 **Oxygen/ Sleep Apnea**	
Oxygen? **Yes No Flow rate ____lpm**	CPAP/BiPAP/ **Yes No** Pressure**: _____**
Last sleep study date:	Location of last sleep study:
DME Company name (For CPAP or Home Oxygen):	
13 **Substance Use**	
Do you smoke? **Yes No**	If YES, how many packs /day
How many years did you smoke?_____	If you quit smoking, when did you quit?
Do you vape or e-cig? **Yes No**	Recreational drug use? **Yes No**
How much alcohol do you drink?	

14 **Are there any other issues you would like to addres with the doctor today?**

_____

_____

Patient Name: _____

MEDICATION LOG

RESPIRATORY AND SLEEP DISORDERS SPECIALISTS

Medication Name	Dosage	Frequency	Prescribing MD

Are you allergic to any medications?	
Medication	**Reaction**

Patient Name: _____

Acknowledgement of Receipt, Notice of Privacy Information Practices

I, _____acknowledge and agree that I have received a copy of the Notice of Privacy Practices for Millennium RSDS.

Signature _____ Date: _____

If patient did not sign, Millennium RSDS gave good efforts to obtain the above referenced individuals written acknowledgement of receipt of Notice Privacy Practices. (Identify the efforts that were made to obtain the individuals written acknowledgment, including the reasons (if known) why written acknowledgement was not obtained)

No Show/ Cancellation Policy

If you cancel your appointment with less than 24 hours' notice, this is a no show appointment and you could be charged a fee of **$35** that will be payable before you can reschedule your appointment. This will not be covered by your insurance.

Initials: _____

Sleep Study No Show/Cancellation Policy

If you cancel your sleep study with less than 24 hours' notice or by Friday morning for Saturday or Sunday night, you could be charged a **$250** fee which is the cost we pay to reserve the technician for the sleep study. This will be payable before your next sleep study will be rescheduled. To cancel your sleep study,

please call 281-296-8788, ext. 7529.

Initials _____

Patient Portal Policy

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communication between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information.

Patient Name printed: _____ Date of Birth: _____

Email Address: _____

Signature: _____ Relationship:_____ Date: _____

Authorization for Disclosure of Confidential Information

Patient Name: _____

RESPIRATORY AND SLEEP DISORDERS SPECIALISTS

Date of Birth: _____ SSN: _____

Street Address _____

I hereby authorize Respiratory and Sleep Disorder Specialists to:

Release to: _____ Receive from: _____

Name of Person/Facility: _____

Street Address: _____

City, State, Zip: _____

Phone/Fax: _____

Please fax records to 281-419-1291

____ History & Physical ____ Discharge Summary ____ PFT

____ Progress Notes ____ Sleep Studies ____ Lab Results

____ Pathology Results ____ Radiology Reports ____ Other: _____

The authorization covers patient care given from _____to _____.

Purpose of Disclosure: _____Medical Care _____Attorney _____Insurance _____Other

I understand that I may revoke this authorization in writing at any time except to the extent that the action has been taken in reliance on it and that any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state regulations.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to who it pertains, or as permitted by such regulations. A general authorization for the release of information is not sufficient.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Patient Signature: _____ Date: _____

Witness Signature: _____Date: _____

Respiratory & Sleep Disorder Specialists