Medical History Form

Name: **DOB:**
What is your chief Complaint?
Shortness of Breath: **At Rest?** **With Activity?** **(circle all that apply)** **At night?** **Lying flat to sleep?** **Duration? _____**
Able to walk a block? Y or N **Climb a flight of stairs? Y or N**
History of Cough? Y or N **For How Long? _____** **Do you cough up phlegm? _____** **What color? _____**
History of coughing up blood? Y or N
Is your cough worse in the (circle one) morning bedtime all day
History of Wheezing: **With Activity? Y or N** **With cold or Humid Weather? Y or N** **At Bedtime? Y or N**
Frequency of Wheezing (check one) ____Every day _____ Once a week **___ 3 or more times a week ____Once a month**
History of Allergies? Y or N **Hay Fever? Y or N** **Postnasal drainage? Y or N**
History of (circle all that apply): Recurrent Bronchitis Pneumonia Asthma COPD Emphysema Tuberculosis Fibrosis Blood Clot Pulmonary Hypertension
Sleep History: **Have you been told that you "quit breathing"? Y or N** **Do you wake up tired? Y or N** **Dreams? Y or N** **History of Loud Snoring? Y or N** **Falls asleep quickly? Y or N** **Number of awakenings at night? _____**
Are you sleepy during the daytime? Y or N **Time to bed: _____ PM** **Wake up time: _____ AM**
How many naps during the daytime? None 1 2 3+
Do you have a history of restless sleep? Y or N **Do you use a feather pillow? Y or N**
Do you have a morning headache? Y or N

Do you have a history of increased limb movements in the evening? Y or N
Do you have a history of "creeping and/or crawling" sensation in your legs in the evening? Y or N

History of (circle all that apply): sleep walking narcolepsy restless legs sleep apnea seizures

<u>Occupational History:</u>
Have you worked in or with: asbestos foundry sandblasting welding quarry

<u>Marital Status</u>:
____ Married _____ Single _____ Divorced _____ Separated _____ Widowed

<u>Tobacco History:</u> Cigarettes Cigars Pipe Chewing Snuff Dip
E-Cigs/ Vaping
Never Past Active
Date started: _____ Date stopped: _____
How much (e.g. pack per day) _____

<u>Alcohol History</u>: Never Past Active
Liquor Beer Wine _____ drinks per _____

<u>Illicit Drug Use:</u> Never Past Active
Drug Type: _____

<u>Caffeine Use:</u> Never Past Active
Coffee Tea Soda _____ cans/ cups per day

<u>Pets in the house?</u> Y or N How Many? _____
Type?_____
_____

Animal Exposure? Y or N Past or Present?
Type of Animal(s):
_____
_____

Indoor Plants? Y or N

<u>Allergies:</u>
_____
_____
_____

<u>Current Medications:</u>

Surgical History (Circle All that Apply):

Cataract (RT/LT)	**Hip (RT/LT)**	**Glaucoma (RT/LT)**	**Knee (RT/LT)**
Hernia (Umbilical/Inguinal/ Ventral)		**Coronary Bypass**	**Pacemaker**
Heart Valve Surgery	**AICD**	**Lung Surgery**	**Tonsillectomy**
Appendectomy	**C Section**	**Hysterectomy**	**Oophorectomy**
Back	**Gastric Bypass**	**Sinus**	**Gallbladder**
Aneurism (Brain/Chest/Abdomen)		**Vascular Bypass**	**Vascular Stent**
Cardiac Stent/ Angioplasty	**Bladder Lift**	**Nasal septum**	

Medical History (Circle All that Apply):

		Hypertension	**Diabetes Mellitus**
Stroke	**Coronary Artery Disease**	**Heart Attack**	**Atrial Fibrillation**
Cataract	**Glaucoma**	**Cancer**	**Congestive Heart Failure**
Arthritis	**Asthma**	**COPD**	**Anxiety**
Depression	**Chronic Kidney Disease**	**Blood Clot to Leg**	**Blood Clot to Lung**
Acid Reflux	**Poor Circulation (Peripheral Vasc Disease)**		**Prostate Enlargement**
Ulcers	**Increased Cholesterol**	**Thyroid**	**Sleep Apnea**
Restless Leg Syndrome	**Kidney Stones**		

Other:_____

_____

_____

_____

_____

Family Medical History:

Father-

Age_____ Alive/ Deceased

Medical History:

_____

_____

_____

Mother-

Age_____ Alive/ Deceased

Medical History:

_____

_____

_____

Siblings-

How Many? _____ Ages? _____ Alive/ Deceased _____

Medical History:

_____

_____

Other-

CIRCLE all the conditions you have had:

General:	**HEENT:**	**Musculoskeletal:**
Weight Loss	**Eye Problems**	**Arthritis**
Weight Gain	**Hearing Defect**	**Back Pain**
Heartburn	**Nasal Congestion**	**Osteoporosis**
Nausea	**Sore Throat**	**Fibromyalgia**
Night Sweat		
Vomiting		
Fever		
Diarrhea		
Constipation		
Colon Polyp		

CVS:	**Skin:**	**Neuro/ Psychiatry:**
Chest Pain	**Psoriasis**	**Anxiety**
Irregular Heart Beat	**Eczema**	**Depression**
Heart Murmur		**Stroke**
Heart Failure		**Numbness**
Valve Prolapse		**Vertigo**
Blocked Artery		**Tremors**
High Cholesterol		**Dizziness**

Urinary Symptoms: Burning Blood in the Urine Hesitancy
Dribbling Kidney Disease

Have you had a:

Flu Shot?	**Y**	**N**	**Date: _____**	**Location: _____**
Pneumococcal 23 shot?	**Y**	**N**	**Date: _____**	**Location: _____**
Prevnar 12 shot?	**Y**	**N**	**Date: _____**	**Location: _____**
Shingles shot?	**Y**	**N**	**Date: _____**	**Location: _____**
DTP Shot?	**Y**	**N**	**Date: _____**	**Location: _____**
COVID 19- 1st shot?	**Y**	**N**	**Date: _____**	**Location: _____**
COVID 19- 2nd shot?	**Y**	**N**	**Date: _____**	**Location: _____**

SIYER PA

Epworth Sleepiness Scale

Use this scale to determine your level of sleepiness.

Choose the most appropriate number for each situation:

Situation Chance of Dozing or Sleeping:

0 = no chance of dozing
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a motor vehicle for an hour or more	
Lying down to rest in the afternoon when circumstances permits	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score	

NEW PATIENT DEMOGRAPHICS

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security #: _____ **Race:** _____ **Ethnicity:** _____

Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner/Common Law Spouse

Email Address: _____

Employer Name: _____

Primary Phone #: _____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Secondary Phone #: _____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Emergency Contact Name: _____ **Relationship:** _____

Phone #: _____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Would you like to receive text messages for appointment reminders? ☐ Yes ☐ No

Can we leave a detailed message or voicemail on either phone number above? ☐ Yes ☐ No

Would you like to be enrolled in the Healow Patient Portal? ☐ Yes ☐ No If yes, please add your email above

Primary Care Doctor: _____

City/State/Zip: _____ **Phone Number:** _____

Referring Doctor: _____

City/State/Zip: _____ **Phone Number:** _____

Preferred Pharmacy Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Secondary Pharmacy Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Preferred Mail Order Pharmacy: _____

Please list anyone below you would like us to be able to communicate with regarding your medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Do you have any of the following? ☐ Advance Directives ☐ Medical Power of Attorney ☐ Do Not Resuscitate
If so, please plan to bring a copy to your appointment so we can add it to your chart. If you do not have them with you, please bring them to your next appointment.

OFFICE POLICIES AND PATIENT INFORMATION ACKNOWLEDGEMENT

Your signature below indicates you have been offered the patient policies and patient information booklet and agree to the patient policies of our practice. You have a right to receive a copy of each of these policies which are available at the front desk and on our website. If you have any questions regarding any of these policies, please ask to speak with the Office Manager for more information.

- No Show Policy
- Late Arrivals Policy
- Financial Policy
- Insurance Policy
- Referral Policy
- Refill Policy
- Termination of Care Policy
- After Hours Calls
- Patient Portal
- Notice of Privacy Practices
- Notification Regarding Radiology and Laboratory Services

FINANCIAL RESPONSIBILITY POLICY AND INSURANCE ASSIGNMENT

I, the undersigned below, request that payment of authorized medical insurance benefits be made on my behalf to S Iyer PA, for services furnished to me by any provider associated with S Iyer PA. I authorize any holder of medical information about me to release to the appropriate medical insurance administration and its agents any information needed to determine benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other claim forms, my signature authorizes releasing the information to the insurer or agency shown.

If so determined by written contract between S Iyer PA and my medical insurer, then S Iyer PA accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the medical insurance carrier. If no contract exists between S Iyer PA and my insurance, then I agree to accept full responsibility for the difference between the insurance reimbursement received by S Iyer PA and the charges for services rendered. If I represent that I have medical insurance, I accept responsibility of all charges for services furnished to me by S Iyer PA in the event that is determined that I was not eligible or authorized to receive such services at the time of service. If I provide insurance information that is incorrect or invalid, I accept responsibility of all charges for payment for services. I understand that at the time of service, I am responsible for payment in full of any copay, out-of-network visit cost, prior outstanding balances, deductibles, and coinsurances.

If I do not fulfill my financial obligation to S Iyer PA, I will be sent written invoices detailing my obligation by S Iyer PA. At the discretion of S Iyer PA, my account may be referred to a collection agency for failure to clear an outstanding balance. If I am referred to collections, a collections fee will be added to my balance due along with any costs (including attorney fees, court costs, and filing fees) necessary to enforce collection of the amount due. S Iyer PA accepts cash, check, and credit cards. If a personal check is returned by the bank for any reason, the patient will be responsible for a returned check fee of $40.00, which includes the bank's returned check fee and office administrative cost for handling the returned check.

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. By signing this document, you agree to the statements above.

Patient or Patient Representative's Signature _____ Date _____

OFFICE POLICIES AND PATIENT INFORMATION

NO SHOW POLICY

Our practice charges a $40 fee for each no-showed appointment, or appointments cancelled less than 24 hours before the appointment time. If you no-show to more than three (3) appointments, you will be discharged from the practice. We will forward your records at no charge to another physician of your choosing.

LATE ARRIVALS

We work hard to stay on schedule to respect your time. To stay on schedule, we ask you to arrive 10 minutes before your appointment. If you are a new patient to the practice, you should arrive 20 to 30 minutes before your appointment to give yourself plenty of time to finish all the necessary paperwork. Arriving later than the recommended times, you are subject to more extended waiting periods. Patients who arrive more than ten (10) minutes past their appointment time may be rescheduled for another day.

FINANCIAL POLICY

All patients are required to complete a patient information form and present a valid form of identification along with their insurance card before being seen by a provider. All co-payments, deductibles, and other fees are due at the time of service. Full payment is due at the time of service unless other payment arrangements have been made. Copays, deductibles, co-insurance, and balances are also expected at the time of service.

INSURANCE POLICIES

Services performed or provided by this office will be billed to your insurance. This includes provider visits, sleep studies, pulmonary function tests, injections, etc. Once the insurance has processed your claim, we will send you the invoice for the patient responsibility provided to us by your insurance company. Delays in insurance occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering the services provided. When an insurance company denies payment for a service, it is the patient's responsibility to cover the charges. In the event your insurance plan determines a service to be "a non-covered service", you will be responsible for all non-covered and allowable charges. Therefore, it is important to review your benefits with your insurance provider. If you would like to have a patient estimate prior to the services being performed, please contact the office. Please NOTE: The balance that we quote you at the time of services is ONLY an estimate. You may still receive a bill for any remaining balance after your insurance carrier processes your claim. If you have insurance but decline to use it, please be aware that you will be charged full fee for all service(s) rendered. If you are uninsured, please ask about self-pay rates.

INSURANCE REFERRAL POLICY

Certain Insurances require a referral number for your visit to be paid. This referral number must be obtained by your Primary Care Physician (that the insurance has listed) before coming into your appointment. While we make every attempt at getting this referral number, it is ultimately the responsibility of the patient to make sure that the referral number is received. If this referral is not received, the patient has the option to reschedule the appointment or be seen as a self-pay patient.

PRESCRIPTION REFILL POLICY

All prescription refill requests should originate from the patient by contacting their pharmacist asking to request the refill electronically. All refill requests should be approved or disapproved by our office within 48 business hours. Routine prescription refills will not be fulfilled during the weekends or after office hours. Please plan ahead. You may also request your refills through the patient portal. This may be an easier option. All chronic, non-controlled medications will require at least a 6 month follow up unless your provider recommends otherwise.

TERMINATION OF CARE POLICY

We pride ourselves on our patient-physician relationship and will strive to maintain a professional and respectful relationship. Unfortunately, there may be a time when we deem a patient-physician relationship to be unhealthy due to non-compliance to treatment plan, unacceptable behavior, or nonadherence to clinic policies. At this point, we have the right to terminate the relationship. We will provide a written letter to notify you of the termination. We will continue providing you care for 30 days after the termination letter for urgent medical needs. This will give you an appropriate time to find another provider to address your medical needs. Physical and verbal abuse towards office staff will not be tolerated. This includes offensive behavior on the telephone with office personnel. Abusive behavior may result in immediate dismissal from the practice.

AFTER HOURS CALLS

If you are experiencing a life-threatening medical emergency, call 911. If you need urgent but not emergency assistance during non-business hours, please call the office. A provider is on call 24 hours a day after hours only for urgent matters, not for routine business.

After hour emergency calls are handled by our answering service. They will contact the on-call provider on your behalf. We may bill the insurance if the provider is contacted after hours. Any balance not paid by the insurance will be patient responsibility. After hour line is not for refills. Please follow the refill policy.

PATIENT PORTAL

While we encourage the use of the portal, please be aware that portal messages will NOT be answered after office hours, on weekends, or on holidays. Please use the main office phone number for emergencies/urgent matters, Disability forms, letters, etc. Please inform the office staff if you have any forms you need completed when you arrive, or by phone when you schedule an appointment.

NOTIFICATION REGARDING RADIOLOGY AND LABORATORY SERVICES

Please be advised that if you receive technical services such as x-rays, labs, and pathology, you may be billed the professional services by other providers as well. For example, your pathologist and radiologist (those who interpret lab and x-rays) bill separately from our clinic and may not participate in the same health plans as S Iyer PA. You will be responsible for paying these providers subject to the terms of your health plan or insurance, if any. If you have any questions regarding your bill, please call the number located on the statement you receive.

NOTICE OF PRIVACY PRACTICES

S Iyer PA is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at S Iyer PA, please contact our office.

- Health information will be disclosed to appropriate staff and fellow medical providers to offer comprehensive medical care and provide for your continuity of care. For example, we may share medical information with other physicians who are treating you, or with a pharmacist who is filling a prescription on your behalf.
- Payment. We will disclose health information to health plans or other parties who provide you with health insurance and services coverage to secure payment. We may also disclose information to other health care providers who have treated you to assist them in obtaining payment.
- Regular Health Care Operations. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews audits, including fraud and abuse detection and compliance programs and business planning and management. We may share information with a local regional health information organization for purposes of continuity of care and reviewing quality of care.
- Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. If you do not agree to this, you may update information listed on the Patient Communication Form.
- Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition, assistance in your health care, or in the event of your death. If there is anyone that you do not want to receive your medical record information, please add their name to the Patient Communication Form
- Public health. As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
- Health oversight activities. We may disclose your health information to health agencies during audits, investigations, inspections, licensure, and other proceedings.
- Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors, or valid personal representatives or those with legal authority.
- Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.
- Health plan. We may disclose your health information to the sponsor of your health plan or your health plan as required by our participating agreement.

You have the right to request restrictions on certain uses and disclosures of your health information. S Iyer PA may charge you a reasonable cost-based fee for copies of your medical records. This fee is to cover the cost of supplies and employee time. Changes to this Notice of Privacy Practices. S Iyer PA reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, S Iyer PA is required by law to comply with this Notice. All revisions will be posted in the office locations. V. Complaints: Complaints about this Notice of Privacy Practices or how S Iyer PA handles your health information should be directed to our office. You will not be penalized or retaliated against for making a complaint. If you are not satisfied with the manner that this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services Office of Civil Rights 200 Independence Avenue, S.W.
Washington, D.C. 20201