Pulmonary. Critical Care. Sleep

Today's Date: _____ **Home Phone:** (____) _____-_____

Cell Phone: (____) _____-_____

Patient Information

Name: _____,_____
Last Name, First Name Middle Initial

Sex: F / M **Age:** _____ **Birthdate:** _____

Social Security Number: _____
(For Medicare/Medicaid Patients)

Address: _____

City: _____ **ZIP:** _____

Marital Status: **Married** **Domestic Partner** **Separated** **Divorced** **Widowed** **Single** **Minor**
(Please circle)

Referring Physician/Primary Physician (if different): _____,_____
Last Name , First Name

Primary Language: _____ **Translator Needed:** **Yes** / **No**

Occupation: _____ **Employer/ School:** _____

Employer/School Address: _____

Employer/School Phone: (_____) _____-_____

Emergency Contact Information

In case of emergency who should be notified: _____,_____
Last Name, First Name

Relation to Patient: _____ **Birthdate:** _____

Address (if different from patient's): _____

Emergency Phone Number: (_____) _____-_____

Insurance Information

Medical Insurance: Yes / No

Name of Primary Insurer: _____ Policy Holder:_____

Contact Number: (_____) _____-_____ Group Number: _____

Subscriber Number: _____

Name of Secondary Insurer (if any): _____ Policy Holder: _____

Contact Number: (_____) _____-_____ Group Number: _____

Subscriber Number: _____

Are you on the Medi-Cal Program: Yes / No

Are you on the Medicare/Medi-Cal Program: Yes / No

Do you have Medicare: Yes / No Medicare Number and Letter: _____

If yes, please provide your Social Security Number: _____

Authorization for treatment and financial agreement:

I authorize treatment for myself and/or patient. I agree to pay all fees and charges for such treatment at the time they are incurred, unless previous arrangements have been made in advance. I authorize *Pacific Pulmonary Medical Group* to use any and all medications deemed necessary during the course of treatment up to and including emergency services.

Authorization to pay benefits to physician:

I hereby authorize payment directly to *Pacific Pulmonary Medical Group* for Medical/Surgical Benefits otherwise afforded me. I authorize *Pacific Pulmonary Medical Group* to release any and/or all medical records to my Insurance Company which are deemed necessary to secure payment for the services rendered.

Please Sign Here: _____ Date:_____

(Print Name Below)

APPOINTMENT & CANCELLATION POLICY

BY APPOINTMENT ONLY

Pacific Pulmonary Medical Group sees patients by appointment only. We make every effort to provide prompt medical care to all of our patients. If you arrive in our clinic as a walk-in, please understand that you will be asked to schedule an appointment for a different time.

It is your responsibility to know when your next appointment is scheduled. We do make reminder calls as a courtesy; however, the responsibility of remembering your appointment is still yours regardless of whether or not we are able to reach you by phone.

LATE ARRIVALS

We make every effort to maintain appointment time commitments and we request that you extend the same courtesy to us. If you are running late, please call our clinic to notify us and reschedule if needed. We understand that special circumstances can arise, which may cause you to run a few minutes behind. On occasion we are able to work-in late arrivals into the schedule; however, this is at the discretion of our front office staff. Additionally, if a patient is more than 15 minutes late to his/her appointment without prior notification, we reserve the right to cancel the appointment and the cancellation fee of **$50.00** will apply.

MISSED APPOINTMENTS (NO SHOWS)

The staff at Pacific Pulmonary Medical Group respects your time and we ask for the same courtesy. Missed appointments (no shows) affect our ability to provide timely attention to our patients. When a patient does not show up for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our clinic at least **24** hours in advance. Failure to cancel an appointment that you do not attend will be considered a missed appointment or no show.

If you miss your appointment or cancel any time after 9:00 am the day of, *Pacific Pulmonology Medical Group* reserves the right to bill you **$50.00** for each no-show or late cancellation. Repeated cancellations and no shows jeopardize your health and quality of care you receive but could result in a discharge from our clinic. You are directly responsible for payment of the no show fee on or before your next appointment. The no show fee cannot be billed to your insurance company.

4234 Riverwalk Pkwy, Suite 230 | Riverside, CA 92505 Tel (951) 781-3672 | Fax (951) 781-0365

THANK YOU FOR YOUR PATIENCE

We value you as our patient and know your time is valuable and we are always looking for ways to improve our ability to manage the rapid growth of new patients. It may seem that you are waiting a long time or that patients who arrive after you are being taken first. Please understand that waiting patients may not necessarily get called back in the order they arrive at our clinic. This is due to simultaneous appointment schedules, which are specific to multiple treatment services in our clinic.

Thank you for understanding the importance of keeping your appointment.

I have read and understand the Patient No-Show and Cancellation Policy of the practice and I agree to the terms. I also understand that such terms may be amended periodically by the practice.

Print Patient Name _____ Date of Birth _____

Signature of Patient _____ Date _____

PRE SLEEP STUDY QUESTIONNAIRE

Date:_____

Patient Name:_____ Phone:_____

DOB:_____ Age:_____ Height:_____ Weight:_____

Please list any medical problems within the last five years (hypertension diabetes, surgeries, etc.):_____

_____

Have you suffered from a heart attack or stroke?_____ If yes, date:_____

1.	Have you been told that you snore at night?	Yes	No	Occasionally
2.	Have you been told that you stop breathing during sleep?	Yes	No	Occasionally
3.	Do you have difficulty falling asleep?	Yes	No	Occasionally
4.	Do you have difficulty maintaining sleep?	Yes	No	Occasionally
5.	Do you experience a restless sensation in your legs while lying awake?	Yes	No	Occasionally
6.	Do you kick and/or twitch while you are asleep?	Yes	No	Occasionally
7.	Do you experience excessive daytime tiredness?	Yes	No	Occasionally
8.	Have you ever awakened feeling paralyzed?	Yes	No	Occasionally
9.	Have you experienced a sudden loss of strength in your arms or legs?	Yes	No	Occasionally
10.	If you answered "yes" to any of the previous questions, were these events brought on by a sudden frightening event or laughter?	Yes	No	Occasionally

Do you frequently awaken with (please circle all that apply)

Dry mouth Nasal congestion Headache Heartburn Chest pain

Sweating Choking or gasping Feeling groggy Feeling un-refreshed

According to the following scale, circle the appropriate number value to represent **how likely you are to fall asleep during the day** in the listed situations. Try to be as honest as possible. It would be helpful to have your spouse or significant other assist you in this rating.

0 – Never 1 – Slight chance 2 – Moderate 3 – Always

Sitting and Reading _____ 0 1 2 3

Watching TV _____ 0 1 2 3

Sitting, inactive in a public place (movie, meeting, theater) _____ 0 1 2 3

Sitting and talking to someone _____ 0 1 2 3

Sitting quietly after lunch without alcohol _____ 0 1 2 3

As a passenger in a car for an hour without a break _____ 0 1 2 3

Driving a vehicle for two or more hours _____ 0 1 2 3

Lying down to rest in the afternoon when circumstances permit _____ 0 1 2 3

Total _____

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HEALTH QUESTIONNAIRE

Name_____ Age_____ Date_____

Address _____ Phone _____

PAST MEDICAL HISTORY **Please circle and indicate as necessary**

Stroke	No	Yes
Heart disease	No	Yes
Kidney disease	No	Yes
Cholesterol	No	Yes
High Blood Pressure	No	Yes
Diabetes	No	Yes
Thyroid	No	Yes
Have you had any serious illness?	No	Yes
Have you ever been hospitalized or been under medical care for very long?	No	Yes

If yes for what reason? _____

SURGERIES

Have you had any surgery? ..... No Yes

List _____ _____

_____ _____

SOCIAL HISTORY

Lives with: _____

Marital Status: Single Married Separated Divorced Widowed

Do you have dependents at home? _____

Alcoholic Beverages: Never_____ Rarely_____ Moderately_____ Daily_____ Ever_____

Caffeine Intake: None _____ Two Caffeine Beverage_____ Heavy Caffeine_____

Illicit drug: ..... No Yes

Smoking: Non-Smoker_____ Ex-Smoker_____ Smoker_____

Passive smoking: ..... No Yes

Your occupation: _____

Occupational exposure to respiratory irritants: ..... No Yes

Exercise: ..... No Yes

FAMILY HISTORY

Indicate if your mother, father, brother(s), sister(s) have or had one or more.

Breast Cancer:	mother	father	brother	sister	aunt/uncle	grandparents	none
Colon Cancer:	mother	father	brother	sister	aunt/uncle	grandparents	none
Stroke:	mother	father	brother	sister	aunt/uncle	grandparents	none
Diabetes:	mother	father	brother	sister	aunt/uncle	grandparents	none
Heart Disease:	mother	father	brother	sister	aunt/uncle	grandparents	none
High Cholesterol:	mother	father	brother	sister	aunt/uncle	grandparents	none
Hypertension:	mother	father	brother	sister	aunt/uncle	grandparents	none
Kidney Disease:	mother	father	brother	sister	aunt/uncle	grandparents	none
Thyroid Problem:	mother	father	brother	sister	aunt/uncle	grandparents	none

Physician Signature: _____ Patient Signature: _____

Pacific Pulmonary Medical Group
4234 Riverwalk Parkway, Suite 230
Riverside, CA 92505

To contact our privacy officer, please call: (714) 624-1204

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by email at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____