SIYER PA

Dr. Sridhar K. Iyer, MD, FCCP, FAASM

Pulmonary/ Sleep Medicine

802 N. Bonnie Brae Street, Suite 104

Denton, Texas 76201

Ph: (940) 565-0373

Fax: (940) 565-0413

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip Code:_____

Patient SSN:_____ Race:_____ Age:_____

Married Single Divorced Widowed Significant Other

Primary Phone #:_____ Secondary Phone #:_____

Would you like to receive Text Message Reminders? Yes No If Yes, to what Cell Phone #:_____

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Phone Number: _____

Language(s) Spoken: _____

Primary Care Doctor:_____ Phone Number: _____

Referring Doctor: _____ Phone Number: _____

Local Pharmacy Name and Location:_____

Phone Number: _____ Mail Order Pharmacy: _____

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less 24 hours notification may be subject to a $25.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients who No-Show three (3) or more times may be dismissed from the practice thus they will be denied any future appointments. *Patients will also be subject to a $25.00 fee for an appointment No-Show. The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.*

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based on understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department 1-800-403-4746.

Intial:_____

Medical History Form

Name:	DOB:	Today's Date:

What is your Chief Complaint?

Respiratory Symptoms: (Below Circle Yes or No and/or answer related questions)

Shortness of Breath:

At Rest? Yes No | With Activity? Yes No | At Night? Yes No | Lying Flat to Sleep? Yes No

Able to walk a Block? Yes No	Able to climb a flight of stairs? Yes No

History of Cough? Yes No	For how long?	Cough up phlegm? Yes No	Color of phlegm?

History of coughing up blood?

Your cough is worse in (check one): ___Morning ___Bedtime ___All Day

History of Wheezing:

With Activity? Yes No With Cold or Humid Weather? Yes No At Bedtime? Yes No

Frequency of Wheezing (check one):

___Everyday ___Once a Week ___3 or more times a Week ___Once a month

History of Allergies? Yes No	History of Hay Fever? Yes No	History of Postnasal Drainage? Yes No

History of (check all that apply):

___Recurrent Bronchitis ___Pneumonia ___Asthma ___COPD ___Emphysema
___Tuberculosis ___Fibrosis ___Blood Clot ___Pulmonary Hypertension

Sleep History (Below Circle Yes or No and/or answer related questions):

Have you been told that you "quit breathing"? Yes No Do you wake up tired? Yes No

Are you sleepy during the daytime? Yes No Time to Bed: ___PM Wake Time: ___AM

How many naps do you take during the daytime? (check one) ___None ___1 ___2 ___3+

Do you have a history of restless sleep? Yes No

Do you have a history of increased limb movements in the evening? Yes No

Do you have a history of "Creeping and/or Crawling" sensation in your legs in the evening? Yes No

History of (check all that apply):
___Sleep Walking ___Narcolepsy ___Restless Leg ___Sleep Apnea ___Seizures

Marital Status:

__ Married ___ Single ___ Divorced ___Separated ___Widowed

Occupational History: _____

_____

Have you worked with (check all that apply):

___Asbestos ___Foundry ___Sandblasting

___Welding ___Quarry ___Other (similar)

Tobacco History (Check all that apply & answer questions):

___Cigarettes ___Cigars ___Pipe

___Chewing ___Snuff ___Dip

___Never ___Past ___ Active

Date Started:_____ Date Stopped:_____

How much (ex. Pack a day):_____

Alcohol History (check all that apply &answer questions):

___Never ___Past ___Active

___Liquor ___Beer ___Wine

___Drinks per ___ (ex. 2 Drinks per Day)

Illicit Drug Use (check all that apply & answer the questions):

___Never ___Past ___Active

Drug Type & Frequency:_____

_____

Caffeine Use (check all that apply & answer questions):

___Coffee ___Tea ___Soda

___Never ___Past ___Active

___Cans/Cups/Drinks per ___ (ex. 3 cups per day)

List Allergies: _____

_____

_____

_____

Current Medications: _____

_____

_____

Past Medical History (check all that apply):

___ Hypertension
___Diabetes Mellitus
___Stroke
___Coronary Artery Disease
___Heart Attack
___Congestive Heart Failure
___Atrial Fibrillation
___Blood Clot to Leg
___Blood Clot to Lung
___Arthritis
___Chronic Kidney Disease
___Glaucoma
___Cataract
___Cancer
___Poor Circulation (Peripheral Vasc. Disease)
___Prostate Enlargement
___Acid Reflux
___Ulcer Disease
___Increased Cholesterol
___Others

Past Surgical History (check all that apply):

___Cataract Surgery (RT)/(LT)
___Hip Surgery (RT)/(LT)
___Glaucoma Surgery (RT)/(LT)
___Knee Surgery (RT)/(LT)
___Hernia Surgery (Umbilical)/(Inguinal)/(Ventral)
___Coronary Bypass
___Heart Valve Surgery
___Pacemaker
___AICD
___Lung Surgery
___Tonsillectomy
___Appendectomy
___C Section
___Hysterectomy
___Oophorectomy
___Back Surgery (Upper)/(Middle)/(Lower)
___Gastric Bypass
___Aneurism Surgery (Brain)/(Chest)/(Abdomen)
___Vascular Bypass Surgery
___Cholecystectomy

Family History:

Father:

Mother:

Siblings:

Others:

Review of System (check all the conditions you have)

General/GI:
__Weight Loss
__Weight Gain
__Heartburn
__Nausea
__Night Sweat
__Vomiting
__Fever
__Diarrhea
__Constipation
__Colon Polyp

HEENT:
__Eye Problems
__Hearing Defect
__Nasal Congestion
__Sore Throat
__Voice Change

Urinary Symptoms:
__Burning
__Blood in Urine
__Hesitancy
__Dribbling
__Kidney Disease

Skin:
__Psoriasis
__Eczema
__Skin Cancer

CVS:
__Chest Pain
__Irregular Heart Beat
__Heart Murmur
__Heart Failure
__Valve Prolapse
__Blocked Artery
__High Cholesterol

Neuro/Psychiatry:
__Anxiety
__Depression
__Stroke
__Numbness
__Vertigo
__Tremors
__Dizziness

Musculoskeletal:
__Arthritis
__Back Pain
__Osteoporosis
__Fibromyalgia

Vaccinations
(Month/Year ex: Flu- Jan/2014):
Flu –
Pneumococcal –
Shingles –
DTP –

Consent to Treat:

I hereby give my consent to Dr. Iyer and authorize him to provide my medical treatment. I understand that Dr. Iyer will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Dr. Iyer to perform any additional or different treatment, which is thought necessary should, in an emergency situation, a condition be discovered which was not known previously.

Intial:_____

Patient Financial Policy:

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For you convenience we accept VISA, MasterCard, and Discover.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a proper agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice and I agree to be bound by this term. I also understand and agree that the practice may amend such terms from time to time.

Intial:_____

For the Release of your Personal Medical Information, It is Ok to:

Leave a Message on Voice Mail or Answering Machine? YES NO

Give information/communicate to your Spouse or Significant Other? YES NO

Name:_____

Give information/communicate to Parent/ Child? YES NO

Name:_____

Is there anyone else that you would like us to give information/communicate? YES NO

Name:_____

In there anyone that you **DO NOT** want us to give information/communicate? YES NO

Name:_____

By Signing Below, I hereby attest that I have fully understood and agree to the Statements Above.

Print:_____ **Date:**_____

Sign:_____

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RELEASE OF MEDICAL HISTORY

To whom it may concern:

I, _____, authorize all physicians, hospitals, and medical attendants to furnish any and all of my medical reports, history and information to Dr. Sridhar K. Iyer. This authorization also includes any examination of all hospital records, x-ray films and furnishing of information including opinions.

_____ _____

Patient Signature **Date**