

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.

Initial: _____

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): <u> </u> Morning <u> </u> Bedtime <u> </u> 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):		
<u> </u> Everyday <u> </u> Once a Week <u> </u> 3 or more times a Week <u> </u> 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):		
<u> </u> Recurrent Bronchitis <u> </u> Pneumonia <u> </u> Asthma <u> </u> COPD <u> </u> Emphysema <u> </u> Tuberculosis <u> </u> Fibrosis <u> </u> Blood Clot <u> </u> 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: <u> </u> PM Wake Time: <u> </u> AM		
How many naps do you take during the daytime? (check one) <u> </u> None <u> </u> 1 <u> </u> 2 <u> </u> 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):		
<u> </u> Sleep Walking <u> </u> Narcolepsy <u> </u> Restless Leg <u> </u> Sleep Apnea <u> </u> 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):

- | | |
|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chronic Kidney Disease |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Poor Circulation (Peripheral Vasc. Disease) |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Blood Clot to Leg | <input type="checkbox"/> Ulcer Disease |
| <input type="checkbox"/> Blood Clot to Lung | <input type="checkbox"/> Increased Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Others |

Past Surgical History (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Cataract Surgery (RT)/(LT) | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Hip Surgery (RT)/(LT) | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Glaucoma Surgery (RT)/(LT) | <input type="checkbox"/> C Section |
| <input type="checkbox"/> Knee Surgery (RT)/(LT) | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Hernia Surgery (Umbilical)/(Inguinal)/(Ventral) | <input type="checkbox"/> Oophorectomy |
| <input type="checkbox"/> Coronary Bypass | <input type="checkbox"/> Back Surgery (Upper)/(Middle)/(Lower) |
| <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Gastric Bypass |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Aneurism Surgery (Brain)/(Chest)/(Abdomen) |
| <input type="checkbox"/> AICD | <input type="checkbox"/> Vascular Bypass Surgery |
| <input type="checkbox"/> Lung Surgery | <input type="checkbox"/> 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.

Initial: _____

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.

Initial: _____

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: _____

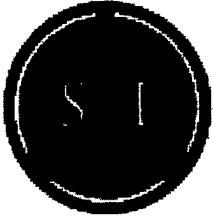
By Signing Below, I hereby attest that I have fully understood and agree to the Statements Above.

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