Houston Pulmonary, Sleep & Allergy Associates

New Patient Registration

Physician Referred By: _____ Primary Care Physician (First & Last Name): _____

Reason for Visit: _____

Patient Information

Last: _____ First: _____ Middle Initial: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

Required for access to our Patient Portal to request refills, make appointments, send messages to provider, schedule Telehealth appointment, etc

Employer: _____

Occupation: _____

Not required. For reporting purposes only

Race:
- ☐ Asian
- ☐ Other: _____
- ☐ Black or African American
- ☐ White
- ☐ Declined to Specify

Ethnicity:
- ☐ Declined to Specify
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Other: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Emergency Contact Information

Name: _____ Relation: _____ Phone #: _____

Patient-Family Communication Authorization

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

I understand I have the right to revoke this authorization in writing at any time to the Practice Manager, except to the extent that action has been taken in reliance upon it. I hereby release and hold harmless Houston Pulmonary, Sleep & Allergy Associates, its physicians, staff, employees, agents, and any other persons involved, from any liability, damage or claim that may result from my authorization of the above communications.

Patient Name: _____ Signature: _____ Date: _____

Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Name: _____ Signature: _____ Date: _____

Updated Financial and Billing Policies

1. You are ultimately responsible for knowing what your insurance plan does and does not cover. This includes in-network/out-of-network benefits, out of pocket, co-payment, co-insurance, deductible, prior authorizations, referrals, etc.
2. Be prepared to show your photo identification and insurance card at every visit.
3. It is your responsibility to make certain that a valid referral is on file should your insurance require one. If there is not a valid referral on file at the time of service, we reserve the right to reschedule your appointment.
4. As a courtesy, we will verify your insurance benefits and eligibility. However, due to insurance policy changes and real-time/up-to-date system information, we cannot guarantee that the information received is accurate.
5. Once your benefits have been determined, payments of any co-pays, co-insurance, deductible, and fees are required at the time services are rendered.
6. Once your insurance company has processed a claim, any balance determined by your insurance company to be "patient's responsibility" and/or "non-covered service", will be your responsibility.
7. If you disagree with the "patient responsibility" amounts due to our office per your insurance's Explanation of Benefits (EOB), please immediately call your insurance company and our billing company, Revele (formally GroupOne), at 800-893-3557 for further explanation.
8. Failure to provide current insurance information to our office and/or reply to insurance's request for additional information may result in the entire bill being your responsibility.
9. Once a payment deemed patient responsibility has not been made on your account after three months, you may be sent to collection agency.
10. For Self-Pay patients, full payment for your visit and any testing (allergy testing, serum, allergy shots, pulmonary function test, spirometry, 6-minute walk, etc.) is expected at the time services are rendered.
11. Any outstanding balance owed to our office is also due, unless payment arrangements have been made in advance with our office.
12. Our office does not bill third parties (i.e.: automobile insurance). Your visit will be self-pay and a receipt will be given to you to file with your auto insurance. Our office does not accept workman's compensation cases.
13. Please notify us in advance if you cannot keep your appointment. We reserve the right to ask you to seek care from another physician if you miss three appointments without notification. If you are more than 30 minutes late for your appointment, you may be asked to reschedule.
14. A $25 fee will be incurred if you do not cancel or reschedule your appointment with at least a 4-hour notice prior to the scheduled appointment time.
15. There will be a $35 fee for all returned checks.
16. There will be a $20 fee for paperwork completion, including but not limited to, FMLA, disability, life insurance, and school physicals. Payment is due prior to completion of the forms.
17. Fees for medical and billing records will be charged per the current allowable set by the Texas Medical Board. Payment is due prior to the processing of the request.

Updated Medication Refill Policies

1. Allow at least one week left on current medication when calling the pharmacy for a refill.
2. Allow at least 48 hours after we receive the refill request from the pharmacy to process the request.
3. Refills will not be processed as an "emergency". Please plan accordingly.
4. Patient is responsible for keeping track of the amount of medication remaining, and for taking the medication as prescribed.
5. No refills will be made during weekends or holidays.
6. Controlled substances require an appointment for every refill. There are no exceptions.
7. Triplicate prescriptions require an appointment every 3-6 months (or sooner if changes are needed).
8. All other maintenance medications require a 3-6 month follow up appointment for consideration on therapeutic regimen and necessary blood work.
9. It is per the discretion of the physician if an appointment will be required before a refill is granted. Many factors and circumstances are considered before a final decision is made.

By signing below, I acknowledge that I have read and understood all the above policy updates.

Patient Name (please print): _____ Date of Birth: _____

Signature: _____ Date: _____

Current Medications

NAME	DOSAGE	FREQUENCY	REASON

Date of Last Influenza Vaccination: _____ **Date of Last Pneumonia Vaccination: _____**

Past Medical History – *Do you have a history of any of the following conditions? Check all that apply.*

- ☐ Hypertension
- ☐ Diabetes
- ☐ COPD
- ☐ Asthma
- ☐ OSA
- ☐ Pulmonary Embolism
- ☐ Deep Vein Thrombosis
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Acid Reflux
- ☐ Emphysema
- ☐ Nasal Allergies

Allergies to Medications/Foods/Environmentals

NAME	REACTION

Surgical History (Not Including Pregnancies)

NAME	PROCEDURE

Hospital Admissions (Not Including Pregnancies)

NAME	REASON FOR ADMISSION

Family History – If any relative listed below has suffered any of the following, please put a check in the box corresponding to the family member and the diagnosis.

FAMILY MEMBER	OSA	COPD	LUNG CANCER	ASTHMA	EMPHYSEMA	STROKE	N/A
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐

Social History

Tobacco Use

☐ Current Smoker When did you start smoking? _____

How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

☐ Former Smoker When did you start smoking? _____ When did you quit smoking? _____

Alcohol Use

Did you have a drink containing alcohol within the past year? ☐ Yes ☐ No

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Drug Use

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No

If yes, what substance? _____

Current Symptoms/Problems

General:	YES	NO
Fevers	☐	☐
Fatigue	☐	☐
Generalized Body Aches	☐	☐
Tiredness	☐	☐
HEENT:		
Headaches	☐	☐
Nasal Drainage	☐	☐
Nasal Congestion	☐	☐
Nose Bleeding	☐	☐
Eyes:		
Itchy eyes	☐	☐
Drainage	☐	☐
Double Vision	☐	☐

Sleep:	YES	NO
Snoring	☐	☐
Waking Up with Difficulty Breathing	☐	☐
Difficulty Falling Asleep	☐	☐
Excessive Daytime Sleepiness	☐	☐
Interrupted Sleep	☐	☐
Genitourinary:		
Increased Urinary Frequency	☐	☐
Pain While Urinating	☐	☐
Blood in Urine	☐	☐
Musculoskeletal:		
Joint Pains	☐	☐
Joint Stiffness	☐	☐
Muscle Pains	☐	☐

Respiratory:	YES	NO
Cough	☐	☐
Chest Congestion	☐	☐
Difficulty Breathing at Rest	☐	☐
Difficulty Breathing on Exertion	☐	☐
Coughing Up Blood	☐	☐

Heart:		
Chest Pain at Rest	☐	☐
Chest Pain on Exertion	☐	☐
Dizziness	☐	☐
Heart Beating Fast	☐	☐
Passing Out	☐	☐

Gastrointestinal:		
Abdominal Pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

Nervous:	YES	NO
Weakness of Arms or Legs	☐	☐
Restless Feeling in Legs	☐	☐

Endocrine:		
Increased Thirst	☐	☐
Increased Appetite	☐	☐
Intolerance to Heat or Cold	☐	☐

Psychiatric:		
Feeling Depressed	☐	☐
Feeling Anxious	☐	☐

Vascular:		
Bruises Easily	☐	☐
Excessive Bleeding on Minor Cuts	☐	☐

Skin:		
Rashes	☐	☐
Itching	☐	☐

Houston Pulmonary, Sleep & Allergy Associates

Sleep Interview Questionnaire

Date: _____ Referring Physician:_____

Last Name: _____ First Name: _____ MI: _____ Male/Female

Marital Status: ___M ___S ___W ___D Religion_____ Race_____

Date of birth: ____/____/_____ Age: ___ SSN: ____-____-____ Occupation_____

Employer: _____ Employer Address: _____

Emergency Contact: _____ Emergency Phone#: _____

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits.

Section I: Main Complaint

1. What is your main sleep complaint? _____
2. How long has this been a problem? _____
3. Were there any events (weight gain, stress, illness, etc.) associated with the onset of your complaints?_____
4. Have you had a sleep study or home screen? ____ How long ago? ____ Where? _____
5. Have you ever used nasal CPAP or BiPAP? No____ Yes ____
   If so, how long? _____ Pressure setting _____ Mask _____

Section II: History of Sleep/Wake Disorder

Epworth Sleepiness Scale (ESS):

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?
Even if you haven't done some of these activities recently, think about how they would have affected you. Use this scale to choose the most appropriate number for each situation:

0 = would never doze 1 = slight chance of dozing
2 = moderate chance of dozing 3 = high chance of dozing

Situation	**Chance of Dozing**			
1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (e.g. theater or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
8. In a car, while stopped in traffic	0	1	2	3

Total _____

Do you fall asleep or become sleepy when:	**Never**	**Sometimes**	**Often**	**Always**
1. Driving?	0	1	2	3
2. At work?	0	1	2	3
3. Do you take intentional naps?	0	1	2	3
4. Do you feel unable to move (paralyzed) when falling asleep?	0	1	2	3

	Never	Sometimes	Often	Always
5. Suddenly awaken choking or gasping for breath?	0	1	2	3
6. Grind your teeth?	0	1	2	3
7. Hold your breath? Or have you been told you stop breathing?	0	1	2	3
8. How would you rate your overall sleepiness?	0	1	2	3
9. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	0	1	2	3
10. Do you think you need a sleeping pill, either prescription drug or over-the-counter sleeping aids in order to fall asleep?	0	1	2	3
11. Have nightmares?	0	1	2	3
12. Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep that is relieved by moving or getting out of bed and walking?	0	1	2	3
13. Toss and turn or have restless sleep?	0	1	2	3
14. Walk or talk in your sleep? (Circle appropriate event)	0	1	2	3
15. Snore?	0	1	2	3
16. Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3
17. Awaken with heartburn or acid reflux? (Acid taste in mouth)	0	1	2	3
18. Wake up with a dry mouth?	0	1	2	3
19. Wake up with headaches?	0	1	2	3
20. Move about or engage in aggressive behaviors while asleep or awakening from sleep?	0	1	2	3
21. Do you consume wine or another alcoholic beverage in order to fall asleep?	0	1	2	3
22. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks?	0	1	2	3
23. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep?	0	1	2	3
24. Do you dread getting into bed because you think you will “never” fall asleep?	0	1	2	3
25. How would you rate your overall sleepiness?	0	1	2	3

Section III: Sleep Habits

1. What time do you go to bed on weekdays? _____ Weekends? _____
2. How long does it take you to fall asleep? _____
3. What percentage do you sleep on your Back ___% Stomach ___% Left/Right side ___/___%
4. a.) How often do you awaken at night? _____
   b.) How long do you stay awake? _____
   c.) What reason? (Bathroom, etc.) _____
5. What time do you get up on weekdays? _____ Weekends? _____
6. How many hours of sleep do you get in a typical night? _____
7. How do you feel in the morning?
   ☐ Very sleepy? ☐ Sleepy, but wake up soon ☐ Wide awake, ready to go _____
8. When do you function best?
   Morning: ☐ Best ☐ Medium ☐ Worst
   Afternoon: ☐ Best ☐ Medium ☐ Worst
   Evening: ☐ Best ☐ Medium ☐ Worst

Section IV: Medical History

Please outline your medical history: Do you have or have ever been told you have:

□ High Blood Pressure	□ Elevated Cholesterol	□ Migraine or Frequent Headaches
□ Sinus Problems	□ Stroke	□ Parkinson's
□ Diabetes	□ GI Disease	□ Dementia (Alzheimer's, etc.)
□ Arthritis	□ Cancer	□ Prior History of Sleep Apnea
□ Thyroid Problems	□ Frequent Nighttime Urination	□ Prior History of Restless Legs
□ Anemia	□ Depression and/or Anxiety	□ Obesity
□ Heart Disease	□ Liver Disease	□ Abnormal behavior during sleep
□ Lung Disease	□ Seizures or Epilepsy	

Past Medical or Surgical History (include all hospitalizations within the past five years)

Problem	Date of onset	Treatment	Resolved/Current

List prescription and over-the-counter medications/drugs you are taking or recently have taken:

Name	Dosage	Frequency	Reason

1. Your weight? _____ Your height? _____
2. Do you smoke? _____ If yes, how long? _____ How much? _____/ day
3. Do you drink alcohol? _____ If yes, how long? _____ How many drinks? ____/ day/wk/mo
4. Do you drink caffeinated beverages (coffee, tea, soda)? _____ How many drinks? ____/ day/wk/mo

General History

1. Are you having any other problems (e.g. stress, anxiety, or pressures)? If yes, explain:
   _____
2. Have you noticed any changes in your mood or irritability lately? If yes, explain:
   _____
3. Have you been depressed lately? If yes, explain:
   _____
4. Have you had any recent problems with your memory or concentration? If yes, explain:
   _____
5. Do you often travel across time zones, thereby affecting your sleep/wake schedule? If yes, explain:
   _____
6. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc.)? If yes, explain:
   _____
7. Do you work night shifts and/or rotating shifts? If yes, explain:
   _____

TO BE COMPLETED BY BED PARTNER

Check any of the following behaviors that you have observed the patient doing while asleep:

- □ Loud Snoring
- □ Sitting up in bed while asleep
- □ Twiting of legs or feet
- □ Pauses in breathing
- □ Grinding teeth
- □ Talking in sleep
- □ Rocking or banging head
- □ Kicking legs while asleep
- □ Getting out of bed while asleep
- □ Becoming very rigid and/or shaking
- □ Sleep Walking

How long have you been aware of the sleep behaviors that you have checked above?

_____
_____
_____

Describe the behaviors checked above in detail. Include the description of activity, time it occurs, frequency during the night and whether it happens every night.

_____
_____
_____
_____
_____

Any additional comments:

_____
_____
_____
_____
_____