Texas Multi-Specialty Group

New Patient Registration

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

Reason for Visit: _____

Patient Information

Last: _____ First: _____ Middle Initial: _____ DOB: _____

Gender: ☐ Male ☐ Female ☐ Other SS#: _____

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, etc.

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: _____

Employer: _____ Occupation: _____

Pharmacy Name & Cross Streets: _____ Pharmacy Phone #: _____

Emergency Contact Information

Name: _____ Relation: _____ Phone #: _____

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 Texas Multi-Specialty Group, 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 your appointment, you will be responsible for the complete charge, or you may 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 department at 281-955-0338, option 7, 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 a 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 will be asked to reschedule.
14. **Failure to cancel your appointment within 48 hours prior to your scheduled appointment will result in a no-show fee automatically applied to your account. The no-show fee amounts are as follows:**
    New Patient & New Hospital Follow-up: $75, PFT & Established Follow-up: $75, Allergy Testing: $75, Established Follow-up: $25
15. There will be a $35 fee for all returned checks.
16. **There will be a $25 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.

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. All other maintenance medications require a 3-6 month follow up appointment for consideration on therapeutic regimen and necessary blood work.
8. 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: _____

I. Current Medications – *Please list your current medications/supplements below. If you already have a list of medications, please give your list to our receptionist and proceed to Section II.*

NAME	DOSAGE	FREQUENCY	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

III. Allergies to Medications/Foods

NAME	REACTION
_____	_____
_____	_____
_____	_____

IV. Surgical History (Not Including Pregnancies)

MONTH/YEAR	PROCEDURE
_____	_____
_____	_____
_____	_____

V. Hospital Admissions (Not Including Pregnancies)

MONTH/YEAR	REASON	HOSPITAL NAME/LOCATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. 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	☐	☐	☐	☐	☐	☐	☐

VII. Social History

Tobacco Use

☐ Non-Smoker ☐ 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? _____

VIII. Current Symptoms/Problems – *Check all that apply.*

General:
☐ Fevers
☐ Fatigue
☐ Generalized Body Aches
☐ Tiredness

HEENT:
☐ Headaches
☐ Nasal Drainage
☐ Nasal Congestion
☐ Nose Bleeding

Eyes:
☐ Itchy Eyes
☐ Drainage
☐ Double Vision

Respiratory:
☐ Cough
☐ Chest Congestion
☐ Difficulty Breathing at Rest
☐ Difficulty Breathing on Exertion
☐ Coughing up blood

Cardiovascular:
☐ Chest Pain at Rest
☐ Chest Pain on Exertion
☐ Dizziness
☐ Heart Beating Fast (Palpitations)
☐ Passing Out

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

Sleep:
☐ Snoring
☐ Waking Up with Difficulty Breathing
☐ Difficulty Falling Asleep
☐ Excessive Daytime Sleepiness
☐ Interrupted Sleep

Nervous:
☐ Weakness of Arms or Legs
☐ Restless Feeling in Leg

Musculoskeletal:
☐ Joint Pains
☐ Joint Stiffness

Genitourinary:
☐ Increased Urine Frequency
☐ Pain While Urinating
☐ Blood in Urine

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

Texas Multi-Specialty Group

Patient Name: _____ DOB: _____

Sleep Interview Questionnaire

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? ☐ Yes ☐ No How long ago? _____ Where? _____
5. Have you ever used nasal CPAP or BiPAP? ☐ Yes ☐ No

   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 have not 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

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

Total _____

Use this scale to choose the most appropriate number for each situation:

0 = Never 1 = Sometimes 2 = Often 3 = Always

1. Do you fall asleep or become sleepy when driving? _____
2. Do you fall asleep or become sleepy while at work? _____
3. Do you take intentional naps? _____
4. Do you feel unable to move (paralyzed) when falling asleep? _____
5. Suddenly awaken choking or gasping for breath? _____
6. Grind your teeth? _____
7. Hold your breath? Or have you been told you stop breathing? _____
8. How would you rate your overall sleepiness? _____
9. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)? _____
10. Do you think you need a sleeping pill, either prescription drug or over the counter sleeping aids to fall asleep? _____
11. Have nightmares? _____
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? _____
13. Toss and turn or have restless sleep? _____

Use this scale to choose the most appropriate number for each situation:

0 = Never 1 = Sometimes 2 = Often 3 = Always

14. Walk or talk in your sleep? _____
15. Snore? _____
16. Do you experience vivid dreamlike episodes when falling asleep? _____
17. Awaken with heartburn or acid reflux? (Acid taste in mouth) _____
18. Wake up with a dry mouth? _____
19. Wake up with headaches? _____
20. Move about or engage in aggressive behaviors while asleep or awakening from sleep? _____
21. Do you consume wine or another alcoholic beverage in order to fall asleep? _____
22. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks? _____
23. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep? _____
24. Do you dread getting into bed because you think you will "never" fall asleep? _____
25. How would you rate your overall sleepiness? _____

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 wake up 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 on 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

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
- ◻ Twitching 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
- ◻ Sleepwalking

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:

_____
_____
_____
_____
_____

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Restless Legs Syndrome Rating Scale

Please rate your symptoms for the following ten questions. Use the scale below to choose the most appropriate number for each question, then total your answers at the bottom.

0 = None 1 = Mild 2 = Moderate 3 = Severe 4 = Very Severe

1. Overall, how would you rate the RLS discomfort in your legs or arms? _____
2. Overall, how would you rate the need to move around because of your RLS symptoms? _____
3. Overall, how severe is your sleep disturbance from your RLS symptoms? _____
4. How severe is your tiredness or sleepiness from your RLS symptoms? _____
5. Overall, how severe is your RLS as a whole? _____
6. Overall, how severe is the impact of your RLS symptoms on your ability to carry out your daily affairs? _____
   IE: carrying out a satisfactory family, home, social, school, or work life
7. How severe is your mood disturbance from your RLS symptoms–for example angry, depressed, sad, anxious, or irritable? _____
8. Overall, how much relief of your RLS arm or leg discomfort do you get from moving around? _____
   4 = No relief
   3 = Slight relief
   2 = Moderate relief
   1 = Either complete or almost complete relief
   0 = No RLS symptoms and therefore question does not apply
9. How often do you get RLS symptoms? _____
   4 = Very severe (6 to 7 days a week)
   3 = Severe (4 to 5 days a week)
   2 = Moderate (2 to 3 days a week)
   1 = Mild (1 day a week or less)
   0 = None
10. When you have RLS symptoms, how severe are they on an average day? _____
    4 = Very severe (8hrs per 24hr day or more
    3 = Severe (3 to 8hrs per 24hr day)
    2 = Moderate (1 to 3hrs per 24hr day)
    1 = Mild (less than 1hr per 24hr day)
    0 = None

Total Score: 0

(continued on next page)

Insomnia Severity Index

Please rate your symptoms for the following ten questions. Choose the number that best describes your answer, then total your answers at the bottom. Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

0 = None 1 = Mild 2 = Moderate 3 = Severe 4 = Very Severe

1. Difficulty falling asleep? _____
2. Difficulty staying asleep? _____
3. Problems waking too early? _____
4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern? _____
   - *4 = Very Dissatisfied*
   - *3 = Dissatisfied*
   - *2 = Moderately Satisfied*
   - *1 = Satisfied*
   - *0 = Very Satisfied*
5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life? _____
   - *4 = Very much noticeable*
   - *3 = Much*
   - *2 = Somewhat*
   - *1 = A little*
   - *0 = Not at all noticeable*
6. How WORRIED/DISTRESSED are you about your current sleep problem? _____
   - *4 = Very much worried*
   - *3 = Much*
   - *2 = Somewhat*
   - *1 = A little*
   - *0 = Not at all worried*
7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY? _____
   - *4 = Very Much Interfering*
   - *3 = Much*
   - *2 = Somewhat*
   - *1 = A little*
   - *0 = Not at all interfering*

Total Score: 0

STOP-BANG Sleep Apnea Questionnaire

Please read the following four questions, mark your answers.

1. Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)? ☐ Yes ☐ No
2. Do you often feel TIRED, fatigued, or sleepy during the daytime? ☐ Yes ☐ No
3. Has anyone OBSERVED you stop breathing during your sleep? ☐ Yes ☐ No
4. Do you have or are you being treated for high blood PRESSURE? ☐ Yes ☐ No

****THE FOLLOWING SECTION WILL BE FILLED OUT BY A MEDICAL ASSISTANT****

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5. BMI more than 35kg/m2? ☐ Yes ☐ No
6. AGE over 50 years old? ☐ Yes ☐ No
7. NECK circumference > 16 inches (40cm)? ☐ Yes ☐ No
8. GENDER: Male? ☐ Yes ☐ No

Total Score: _____

Texas Multi-Specialty Group

Authorization for Release of Health Information

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

Address: _____ **Phone:** _____

I hereby authorize Texas Multi-Specialty Group to:

☐ Release To ☐ Receive From

Person/Organization Name: _____

Address: _____

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

Phone: _____ **Fax:** _____

Purpose of Disclosure: *(Choose only one option below)*

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Other: _____

Information to be disclosed:

☐ All health information	☐ Discharge Summary	☐ Lab/Pathology Reports	☐ Billing Records
☐ Physician Orders	☐ Consultations	☐ Pulmonary Studies (PFT)	☐ Other: _____
☐ Progress Notes	☐ Op/Procedure Reports	☐ EKG/Cardiology Reports	_____
☐ History/Physical Exam	☐ Radiology/Imaging	☐ Sleep Studies	_____

Initials are required to release the following information:

_____ Drug, Alcohol, or Substance Abuse Records

_____ Genetic Information (including Genetic Test Results)

_____ HIV/AIDS Test Results/Treatment

Treatment dates *(required):* _____

Please fax records to 281-469-0741

This authorization is valid for one year after I, or my personal representative, signs this form. I have the right to revoke this authorization in writing any time to the Privacy Office, except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless above-named facility and its parent company from all liability and damages resulting from the lawful release of my protected health information.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative

If you are a Personal Representative signing on behalf of the patient, please indicate your relationship to the patient:

☐ Parent	☐ Legal Guardian	☐ Executor or Person Representative
☐ Power of Attorney	☐ Other: _____	

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