Pulmonary and Sleep Medicine, P.C

Patient Registration

Referring Physician: _____

Family Physician: _____

Friend: _____

Family Member _____

Pharmacy Name and Address

Phone number:

PATIENT INFORMATION(TO BE COMPLETED BY PARENT OR RESPONSIBLE PARTY) DATE: _____

NAME: _____ GENDER: M__ F__ AGE____ DATE OF BIRTH_____

ADDRESS:_____ HEIGHT_____ WEIGHT _____

CITY/SATE:_____ZIP:_____ MARITAL STATUS: SINGLE_____ MARRIED _____

HOME PHONE: (____)_____ DIVORCED_____ WIDOWED _____

WORK PHONE: (____)_____ SS #: _____

EMAIL ADDRESS: _____ EMLOYER: _____

EMERGENCY CONTACT (IF DIFFERENT FROM HOME PHONE NUMBER) ADDRESS:_____

NAME: _____ CITY/STATE _____ZIP:_____

RELATIONSHIP:_____NO: (____)_____ MAY WE CONTACT YOU AT WORK? YES_____ NO____

TO BE COMPLETED BY RESPONSIBLE PARTY (IF OTHER THEN PATIENT)

NAME: _____ RELATIONSHIP TO PATIENT: SELF____ SPOUSE____

ADDRESS:_____ PARENT____ OTHER____

CITY/SATE:_____ZIP:_____ DATE OF BIRTH:_____ SS #: _____

HOME PHONE: (____)_____ EMLOYER: _____

WORK PHONE: (____)_____ ADDRESS:_____

EMAIL ADDRESS: _____ CITY/STATE _____ZIP:_____

MAY WE CONTACT YOU AT WORK? YES_____NO____

INSURANCE INFORMATION (MUST BE COMPLETED)

PLEASE GIVE US ALL INFORMATION REGARDING YOUR INSURANCE PLAN(S). PLEASE SHOW ALL NUMBERS ON CARD(S). IF YOUR BENEFITS DEPEND ON PRE-AUTHORIZATION, IT IS YOUR RESPONSIBILTY TO INFORM US.

PRIMARY PLAN NAME: _____ SECONDARY PLAN NAME:_____

ADDRESS/ PHONE NO: _____ ADDRESS/PHONE NO. _____

INSURED(NAME ON CARD)_____ INSURED (NAME ON CARD) _____

RELATIONSHIP TO PATIENT: SELF____SPOUSE____PARENT____ OTHER____ RELATIONSHIP TO PATIENT: SELF____SPOUSE____PARENT____ OTHER____

INSURED ID NUMBER: _____ INSURED ID NUMBER: _____

GROUP NUMBER:_____ GROUP NUMBER:_____

POLICY HOLDER DATE OF BIRTH: MONTH_____ DAY_____ YEAR_____ POLICY HOLDER DATE OF BIRTH: MONTH_____ DAY_____ YEAR_____

Pulmonary And Sleep Medicine, P.C.

Medical History

DATE_____

NAME:_____ AGE: _____ DATE OF BIRTH:_____

DO YOU SMOKE? YES_____ NO_____ PREVIOUS _____ IF YES , HOW MANY PACKS A DAY?_____

ALLERGIES TO MEDICATION, X-RAY DYES, OR OTHER SUBSTANCES YES_____ NO_____
(IF YES PLEASE LIST NAME OF MEDICATION AND TYPE OF REACTION)

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

(PLEASE LIST AND MEDICAL HISTORY YOU HAVE HAD IN THE PAST OR PRESENT)

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

PLEASE LIST ANY FAMILY MEMBER (INCLUDING PARENTS, GRANDPARENTS, AND SIBLINGS) THAT HAS EVER HAD ANY CHRONIC ILLNESSES.

FAMILY MEMBER:_____ CHRONIC ILLNESS_____

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FAMILY MEMBER:_____ CHRONIC ILLNESS_____

FAMILY MEMBER:_____ CHRONIC ILLNESS_____

CURRENT MEDICATION LIST

MEDICATION_____ MEDICATION _____

MEDICATION_____ MEDICATION _____

MEDICATION_____ MEDICATION _____

MEDICATION_____ MEDICATION _____

MEDICATION_____ MEDICATION _____

Asker Asmi M.D. Pulmonary and Sleep Medicine, P.C.

Patient Authorization Form

By signing below; I hereby authorize my health information, as more specifically described only for the purposes and parties also described below:

- Medical related treatment
- Lab evaluations
- Medications presently or previously prescribed
- Testing

The specific person or class or persons who are authorized to use or disclose my Protected Health Information are, employees of S. Talib Raza, P.C.

The person or class of persons to whom this office may use or disclose my Protected Health Information are (please check the box and or insert name):

- ☐ Referring Physician
- ☐ Non Custodial Parent Name_____
- ☐ Guardian
- ☐ Specialist
  Name_____Address_____
- ☐ Other
  Name_____Address_____

This Authorization shall remain in effect from the date signed below until you leave this practice.

I understand that

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by delivering written notice to: S. Talib Raza, P.C.; 18025 Fort; Riverview, MI 48193
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer by HIPAA.
- I may refuse to sign this authorization ant that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment in which case you may refuse to provide that research-related treatment).

Patient Name_____Signature_____

Relationship to Patient_____Date_____
(if signed by personal representative of Patient)

Asker Asmi M.D.

18025 Fort Street
Riverview, MI 48193

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy reguarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your staff of *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that I may contact this organization at any time at this address of: 18025 Fort; Riverview, MI 48193 for a copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name_____

Signature_____

Relationship to Patient_____

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date_____Signature_____Name_____

Reason_____

Asker Asmi M.D.

18025 Fort Street
Riverview, MI 48193

Patient Bill of Rights

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from their credentialed practitioner complete and current information concerning the diagnosis, proposed treatment, and expected prognosis in terms that the patient may reasonably be expected to understand. When it is not advisable to give such information to the patient, the information should be made available to an appropriate person (medical proxy) on the patient's behalf.

3. The patient has the right to receive the necessary information for medical decision making and the granting of informed consent from the treating credentialed practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure or treatment to be used, who will perform the procedure or treatment, what are the likely benefits from the procedure or treatment, what alternative exist if any, what are the likely risks from the procedure or treatment, what may occur if no treatment is undertaken, and length of probable duration of incapacitation if any is expected.

4. The patient has the right to refuse any and all treatment to the extent permitted by law, and to be informed of any medical consequences of the action.

5. The patient has the right to every consideration of privacy concerning the medical care provided except when there is an imminent risk to the individual or others, or when the practitioner is ordered by a court to breach confidentiality.

6. The patient has the right to be advised if the practitioner, agency, or facility propose to engage in any form of human experimentation affecting the care or treatment provided. The patient has the right to refuse to participate in research projects or to withdraw continued consent to participate without repercussions.

7. The patient has the right to examine and receive an explanation of the bill for professional services rendered.

All medical activities are to be provided with an overriding concern for the patient, and above all, with the recognition of the patient's dignity as a human being.

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ **Your sex:** ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following 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
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:

0-10 Normal range
10-12 Borderline
12-24 Abnormal