**REGISTRATION**

# RESPIRATORY CONSULTANTS OF HOUSTON

PLEASE PRINT **CLEARLY**

**SMITH TOWER**
6550 Fannin St., Suite 2403 ◊ Houston, Texas 77030
**Telephone: (713) 790-6250 ◊ Fax (713) 793-1538**

**MD:**_____

## PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) Birthdate _____ Sex ☐ M ☐ F

Address _____ Apt _____ **Home T** (___) ___ – ____

City _____ State _____ Zip _____ **Cell** (___) ___ – ____

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor Soc.Sec. # ___ – ___ – ____

☐ Partnered for ____ years E-mail _____ @ _____

Patient Employer/School _____ ☐ Retired Occupation _____

Work/School Address _____ Wk/Sc Tel (___) ___ – ____

Whom may we thank for referring you? ☐ Physician ☐ Attorney ☐ Company | Name _____

In emergency, call _____ Relationship _____ Phone (___) ___ – ____

## PRIMARY INSURANCE

Name of Insured _____ (Last Name / First Name / Middle Initial)

Relation to patient _____ Birthdate _____ Soc.Sec. # ___ – ___ – ____

Primary Insurance Company _____ Insur. Tel (___) ___ – ____

Member ID _____ Group # _____ Effective Date _____

Insured Address (If not patient's) _____ Phone (___) ___ – ____

City _____ State _____ Zip _____ Occupation _____

Insured Employer _____ Work Tel (___) ___ – ____

## SECONDARY INSURANCE

Insured Name _____ DOB _____

Secondary Insurance Company _____

Member ID _____ Group # _____

Insurance Tel (___) _____ Effective Date _____

## PHARMACY INFORMATION

Pharmacy Name _____

Phone (___) ___ – ____

Fax (___) ___ – ____

Address _____

City _____ ST ____ ZIP _____

## TERTIARY INSURANCE

Insured Name _____ DOB _____

Tertiary Insurance Company _____ Insur. Tel (___) ___ – ____

Member ID _____ Group # _____ Effective Date _____

## AUTHORIZATION

Effective August 1, 2000, House Bill 610 (Prompt Pay Law) became effective. To be in compliance with this law, it is mandatory that we verify patient health insurance information.

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ DATE

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

V1119

# Respiratory Consultants of Houston

## PERSONAL HEALTH QUESTIONNAIRE

In our effort to individually assess your health care needs, we are requesting that you take the time to complete this questionnaire. Please try to answer all the questions completely to the best of your knowledge. If you do not understand any question, circle its number and the nurse or physician will help explain it.

All this information will become part of your medical record and will be held in strictest confidence. If you do not have time to complete the form before seeing a physician, we will give you a copy to complete at home and you can mail it in. Additional space is provided at the end of the form for any additional comments or questions you would like to ask your physician.

NAME_____ _____ _____
(Last) (First) (Initial) DOB (Spouse's Name)

Home Phone _____ Business Phone _____

Age _____ Sex _____ Height _____ Weight _____ Marital Status: S M D W

How were you referred to our practice?
_____

Are you currently under the care of any physician (s) _____ Yes _____ No
Please list name (s): Tel: ( ) _____ - _____ Fax: ( ) _____ - _____
_____
For what condition?:
_____

1. What conditions most led to your coming here today? (Check all appropriate)
   ____ Cough
   ____ Shortness of breath
   ____ Chest discomfort
   ____ Abnormal chest x-ray
   ____ Primary Care
   ____ Other _____

2. Have you ever had an allergic reaction to any medication? _____ Yes _____ No
   If "Yes", please list and describe the reaction you experienced.
   Name of Drug/Type of Reaction
_____
_____

3. Have you ever had an allergy to any foods or inhalants? _____ Yes _____ No
   If "Yes", please list and describe the reaction you experienced.
   Name of Food or Inhalant/Type of Reaction
_____
_____

4. When did you last have the following?

| | | | |
|---|---|---|---|
| Chest X-Ray | _____ | PAP Smear | _____ |
| General Physical | _____ | Mammogram | _____ |
| Flu Vaccine | _____ | Breast Exam | _____ |
| Pneumonia Vaccine | _____ | Last menstrual period | _____ |
| Tetanus Vaccine | _____ | PSA level | _____ |

Hepatitis Vaccine _____ Prostate Exam _____
Sigmoid/Colon Exam _____

5. Are you currently taking any medication? _____ Yes _____ No
If "Yes", please list and include prescription and non-prescription medications and birth control pills, hormones, etc.

Medication/Dose in mg. (if known)/Times Per Day Taken
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY:

6. Did you ever have a severe childhood illness: _____ Yes _____ No
Please describe: _____

7. Have you ever had any of the following? (please check if YES)

| | | |
|---|---|---|
| _____ Alcoholism | _____ Hepatitis | _____ Thyroid Disease |
| _____ Anemia | _____ High Blood Pressure | _____ Trouble urinating |
| _____ Arthritis | _____ Bleeding Disorders | _____ Sexual dysfunction |
| _____ Nervousness | _____ Heart Disease | _____ Urinary Infections |
| _____ Dizziness | _____ Pacemaker | _____ Depression |
| _____ Cancer | _____ Phlebitis | _____ Insomnia |
| _____ Childhood Asthma | _____ Rheumatic Fever | _____ Excessive Sleepiness |
| _____ Chest pains | _____ Blood Transfusions | _____ Other Sleep disorder |
| _____ Diabetes | _____ Hiatal Hernia | _____ Tattoos |
| _____ Headache | _____ Peptic Ulcer | |
| _____ Stroke | _____ Diverticulosis | |
| _____ Seizures | _____ Used Diet Pills | |
| _____ Other | _____ Elevated Cholesterol/Triglycerides | |

8. Hospital Admissions: Please indicate the year and the reason for admission. Do not include normal pregnancies.

Year Illness or Operation
_____
_____
_____
_____

Have you ever had or been told you had the following?

| | | |
|---|---|---|
| Bronchitis | Yes ___ No ___ | When _____ |
| Emphysema | Yes ___ No ___ | When _____ |
| Pneumonia | Yes ___ No ___ | When _____ |
| Hay Fever | Yes ___ No ___ | When _____ |
| Sinusitis | Yes ___ No ___ | When _____ |
| Chest Surgery | Yes ___ No ___ | When _____ |
| Injury to the Chest | Yes ___ No ___ | When _____ |
| Tuberculosis | _____ Positive TB skin Test | Yes _____ No _____ |

Name _____

9. Do any of the following illnesses "run" in your family?
If "Yes" please check:

____ Diabetes ____ Stroke
____ High Blood Pressure ____ Asthma
____ Heart Disease ____ Emphysema
____ Cancer Lung___ Breast ____ Colon ____ Other _____

SOCIAL HISTORY:

10. Which best indicates your use of alcoholic beverages?
None _____ Occasionally _____ 1 drink daily _____
2 or more per day _____

11. Have you ever smoked cigarettes? _____ Yes ____ No
Do you smoke cigarettes now? _____ Yes ____ No
Age began smoking? _____ Age quit smoking? _____
Average number of packs per day (check one):
____ Less than ½ pack _____ 2 to 3 packs
____ ½ to 1 pack _____ 3 or more packs
____ 1 to 2 packs
Have you ever used tobacco in any other form? _____ Yes ____ No
Check if "Yes": ____ pipe ____ cigar ____ chew ____snuff

Would you like information to help stop smoking? ____ Yes ____ No

12. Are you currently employed outside the home? ____ Yes ____ No
Describe your current job: _____
Number of years in this occupation: _____
Describe prior jobs: _____

13. Have you been regularly exposed to irritating gases, dust or fumes? _____ Yes _____ No

14. Have you ever worked at a job which caused you difficulty breathing or cough, shortness of breath or wheezing? Yes _____ No _____
If "Yes", please describe: _____

15. Describe any health problems or injuries you have experienced connected with your present or past jobs:

_____

_____

_____

16. Have you ever been employed at any of the following occupations? _____ Yes _____ No
(please circle any applicable to you)

| | | |
|---|---|---|
| Insulator or Insulation Worker | Carpenter | Beryllium Worker |
| Pipe Fitter | Woodworker | Longshoreman |
| Sandblaster | Plastics Worker | Aluminum Worker |
| Pottery Worker | Pulp Mill Worker | Painter |
| Farmer | Mica Worker | Shipyard Worker |
| Cotton Mill Worker | Railroad Worker | Boiler Maker |
| Talc Worker | Other Asbestos Exposure | Health Care Worker |

Name _____

17. Are you currently having problems in any of these areas? _____ Yes _____ No
If "Yes", please check:

General:
_____ Weight loss or gain
(more than 10lbs in one year)
_____ Anemia
_____ Febrile illness
_____ Sleep disturbances
_____ Appetite change
_____ Frequent infections or colds
_____ Fatigue
_____ Depression
_____ Nervousness or anxiety attacks
_____ Personality change
_____ Bleeding abnormally from any site
_____ Easy bruising
_____ Osteoporosis

Neurological:
_____ Frequent headaches
_____ Severe headaches
_____ Persistent dizziness
_____ Fainting, loss of consciousness
_____ Change in daily ability to speak, walk
perform any other muscular functions
_____ Occurrence of strange or unusual sensations
_____ Change in vision
_____ Change in hearing
_____ Change in taste
_____ Change in memory, ability to concentrate
or other mental functions

Ear, Nose and Throat:
_____ Sinus problems
_____ Hay fever
_____ Swallowing problem
_____ Dental problems
_____ Bleeding from ear, nose or mouth
_____ Frequent sore throat
_____ Swollen glands or goiter
_____ Mass or enlargement in neck
_____ Swollen lymph glands

Cardiovascular:
_____ Chest pain/tightness
_____ Shortness of breath with exertion
_____ Shortness of breath at night
_____ Shortness of breath when lying flat
_____ Decreased exercise tolerance
_____ Palpitations
_____ Fluid retention/ankle swelling

Gastrointestinal:
_____ Persistent nausea and/or vomiting
_____ Swallowing difficulty
_____ Heartburn
_____ Indigestion
_____ Gas
_____ Abdominal pain
_____ Change in bowel habits
_____ Hemorrhoids
_____ Rectal Bleeding

Genitourinary:
_____ Pain or urination
_____ Difficulty urinating
_____ Incontinence
_____ Sexual problems
_____ Urinary infection
_____ Sexually transmitted infections
_____ Other

Women's Health Issue:
_____ # pregnancies
_____ # live births
_____ # miscarriages
_____ Breast disorders
_____ Menstrual disorders
_____ Birth Control pills
_____ Menopausal Symptoms
_____ Estrogen Replacement

RESPIRATORY SYMPTOMS:

Do you have a cough? _____ Yes _____ No

Do you cough like this on most days (or nights) for as many as 3 months each year? _____ Yes _____ No

How long have you been troubled by cough?_____

Do you usually bring up phlegm from your chest? _____ Yes _____ No

Do you bring up phlegm like this on most days for as many as 3 months each year? _____ Yes _____ No

Have you ever coughed up blood? _____ Yes _____ No

How long have you been troubled by phlegm? _____

Does your chest ever sound wheezy or whistling? _____ Yes _____ No

For how many years has this been present? _____

Have you had two or more episodes of wheezing? _____ Yes _____ No

Have you ever required medicine or treatment for wheezing or shortness of breath?
_____ Yes _____ No If
"Yes", please explain: _____

Do you experience spells of shortness of breath? _____ Yes _____ No

Do you have to walk slower than people your own age on level ground because of breathlessness?
_____ Yes _____ No

Do you ever have to stop for a breath when walking at your own pace on level ground?
_____ Yes _____ No

Circle which activities (if any) make you short of breath. Cross out those activities you cannot do because of breathlessness.

Walking across the room
Walking about your home
Eating
Bathing/Washing your hair
Jogging
Shopping/lifting groceries
Walking a mile
Bicycling
Swimming, playing tennis or similar sports
Housework

Name _____

# Acknowledgement of Review of Notice of Privacy Practices

This practice uses and disclosed health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You may request a copy of this notice at any time. For more information about this notice or our privacy practices, please contact our office.

## Our Promise to You

The privacy of your personal health care information is important to us. We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

### Your Rights Under Federal Privacy Regulation

You may also request that we limit disclosure to family members, other relatives or close personal friends that may or may not be involved in your care.

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that request for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to our office.

### Disclosures that may be made without your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or any opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures.

We may disclose your medical information for public health activities. We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law.

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court or other appropriate legal process.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances.

We may disclose your medical information as required by the Texas Workers' Compensation law.

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, request as necessary by appropriate military command officers (if you are in the military).

_____
Signature of Patient or Personal Representative

_____
Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

# ALLERGY IMPACT QUESTIONNAIRE

**PATIENTS NAME:** _____ **D. O. B.** ____/____/____ **DATE OF SERVICE:** ____/____/____

**OFFICE STAFF ONLY: ICD-9 CODES FOR PATIENT:** _____ : _____ : _____ : _____ : _____

**1.** Do you think you suffer from Allergies? _____ Yes / _____ No

**2.** Are the symptoms all year around or seasonal? Year Long / Seasonal

**3.** How long do your symptoms last during an allergy flare up? Less than 7 days / More than 7 days

**4.** What time of the day are your symptoms the worst? Morning / Afternoon / Night / All day

**5.** Are the symptoms worse in the spring, fall or both? Spring / Fall / Both

**6.** Do you have any sinus drainage issues? _____ Yes / _____ No If Yes, When? AM / PM / All day

**7.** Do you ever have watery or itchy eyes? Always / Most Times / Sometimes / Never

**8.** Do you cough or sneeze on a regular basis? _____ Yes / No _____ If Yes, When? _____

**9.** Do you have regular Upper Respiratory Infections? _____ Yes / _____ No If Yes, < 3 or > 3 per year

**10.** Do you think you might be allergic to Animals? _____ Yes / _____ No

**11.** Have you been diagnosed with Asthma? _____ Yes / _____ No If Yes, When? _____

**12.** Do you have a family history of Asthma? _____ Yes / _____ No

**13.** Have you ever been hospitalized for asthma? _____ Yes / _____ No If Yes, when was the last time? _____

**14.** How long have you resided in your current State? _____ Years / _____ Months

**15.** How long have you lived in your current residence? _____ Years / _____ Months

**16.** Did you have allergies in your previous residence or State? _____ Yes / _____ No

**17.** Are you currently taking any allergy medications? _____ Yes / _____ No

If yes, please list all medications including any over the counter (OTC) medications as well.

_____, _____, _____, _____

**18.** Are you currently taking any blood thinner medications? _____ Yes / _____ No

If yes, please list: _____, _____, _____, _____

**19.** Are you currently taking a beta-blocker for a heart condition? _____ Yes / _____ No / _____ Unsure

**20.** Are you or could you be pregnant? _____ Yes / _____ No

Name:_____ Date:_____

# EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

| Situation | Responses | Score |
|---|---|---|
| **Sitting and Reading** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Watching Television** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Sitting inactive in a public place, for example, a theater or a meeting** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **As a passenger in a car for an hour without breaks** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Lying down to rest in the afternoon** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Sitting and talking to someone** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Sitting quietly after lunch when you've had no alcohol** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **In a car while stopped in traffic** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **TOTAL SCORE** | | |

**A score of 10 or greater indicates a possible sleep disorder. Take the completed form to your doctor.**

| DATE | |
|---|---|

PLEASE WRITE FULL MEDICATION NAME

| Medication (write out full name as written on bottle) | DOSE (QTY & measure) | FREQUENCY (how often) | PRESCRIBER (Who) |
|---|---|---|---|
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**PLEASE NOTE:** Your medication may not be filled if it is not correctly spelled out!

PATIENT: .....

DOB: .....

DOCTOR: .....

# HCFA ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be on my behalf to RESPIRATOTY CONSULTANTS OF HOUSTON, P. A. I authorize any physician with RESPIRATORY CONSULTANTS OF HOUSTON, P. A. to release to the Health Care Financing Administration, Medicare and its agents any information needed to determine these benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Deductible and co-insurance are based upon the charge determination of the Medicare carrier.

_____
Medicare Number

_____ _____
Beneficiary Signature Date

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**By signing this form, I authorize you to use and disclose the protected health information as described below.**

Patient Name _____

Social Security No _____ Date of Birth _____

**I hereby request the following entity to disclose my protected health information:**

Name of Institution _____ FAX _____

Street _____

City _____ State _____ Zip Code _____

**My medical records/health information may be disclosed to the following person(s)/entity:**

Name of Institution _____ FAX _____

Street _____

City _____ State _____ Zip Code _____

**The health information you may release subject to this authorization is as follows:**

_____ All Health Information
_____ History & Physical
_____ Progress Notes
_____ Consultation Reports
_____ Discharge Summary Reports
_____ Laboratory Reports/Results
_____ Radiology Reports and/or Films
_____ Other (Please Specify) _____

**Limitations on the protected health information you may release are subject to the following restrictions:**

_____

_____

**I understand that I have the right to revoke this authorization in writing at any time by sending a written notification to the following address, otherwise the Authorization is valid for 1 year:**

Privacy Office
6550 Fannin, Suite 2403
Houston, Texas 77030
Fax (713) 793-1538 – Tel (713) 790-6250

I understand that if I revoke this authorization, it is not effective if the practice has already acted on a previous authorization by me. Also, I understand that I cannot revoke this authorization if it was obtained as a condition if obtaining insurance coverage, as other laws provide insurers with the right to contest a claim under my insurance policy. I further understand that information is used or disclosed pursuant to this authorization may be subject to a subsequent disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations. In no way will Respiratory Consultants of Houston, PA condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date