David S. Hernandez, M.D.

Board Certified in Pulmonary Medicine

Health Information Questionnaire

www.davidshernandez.com

PLEASE PRINT **Answer all questions. If information does not apply enter N/A.**

Name: _____ DOB: _____

How did you hear about Dr. Hernandez?_____

Are you currently on Hospice: **Yes or No**

Gender: M or F If you are a female, are you pregnant? ☐ Yes ☐ No

Reason for today's visit: _____

How long have you experienced this problem? _____

What are your current symptoms? _____

Do you use oxygen? ☐ Yes ☐ No Do you use a CPAP Machine? ☐ Yes ☐ No

Name of Durable Medical Equipment Company (DME) that you use:_____

Pharmacy: _____ Phone: _____

Are you allergic to any medications or food: ☐ Yes ☐ No

If yes, please list: _____

Please list all medicines you are currently taking (prescribed, over-the-counter, including vitamins and herbs).

Name of Medicine	Dose or strength of Medicine (mg)	How often and when taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Did you get the FLU Vaccine? Yes No If yes, date of the most recent FLU Vacccine?_____

Did you get the Pneumonia Vaccine Y N If yes, date of the most recent Pneumonia Vaccine_____

1619 E. Common St., Suite 902
New Braunfels, TX 78130

Office: (830) 214.0104
Fax (830) 358.7371

Have you ever had or do you now have (please check the appropriate square)

	Yes	No		Yes	No
Heart Attack	☐	☐	Asthma	☐	☐
Atrial Fibrillation	☐	☐	Sleep Apnea	☐	☐
Hypertension	☐	☐	COPD	☐	☐
Stroke	☐	☐	Emphysema	☐	☐
Reflux/GERD	☐	☐	Ulcer (stomach)	☐	☐
Prostate Problems	☐	☐	Liver Disease	☐	☐
Osteo Arthritis	☐	☐	Rheumatoid Arthritis	☐	☐
Kidney Problems	☐	☐	Diabetes I or II	☐	☐
Anemia	☐	☐	TB	☐	☐
Elevated Cholesterol	☐	☐	Congested Heart Failure	☐	☐

List surgeries/Procedures you have had:

Type of Surgery /Procedure	Date	Type of Surgery/Procedure	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Relative:	Deceased	Condition/Diagnosis:
Father	Y or N	_____
Mother	Y or N	_____
Brother (s) Total: _____	Y or N	_____
Sister (s) Total: _____	Y or N	_____

Social History

Occupation: _____ If retired, previous occupation: _____

Have you recently traveled outside of the country? ☐ Yes ☐ No Where? _____

List household pets: _____

List hobbies: _____

Tobacco/Alcohol History

Current smoker ? ☐ Yes ☐ No If yes: ☐ Tobacco (smokeless) ☐ Cigar ☐ Cigarettes

How many packs a day? _____ For how long? _____

Former smoker: Packs/Day: _____ Quit Date: _____

Do you consume alcohol? ☐ Yes ☐ No

Type: ☐ Beer ☐ Wine ☐ Liquor

Amount/Day: _____ How many years? _____

Former alcohol use: ☐ Yes ☐ No Quit Date: _____

Have you or do you use any illicit substances? ☐ Yes ☐ No

If yes, what type? _____

Demographics & Insurance Information Date: _____

Name:_____ SSN_____ DOB:_____AGE: _____

Street Address: _____City: _____State: _____ Zip Code: _____

Phone #_____Cell #:_____ Gender: ☐ Male ☐ Female

Race: _____ Marital Status:_____

****

Primary Care Doctor: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

****

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient: _____

Home Phone #:_____ Cell #: _____Other #: _____

****

INSURANCE INFORMATION

Primary Insurance:_____ Policy #:_____Group #:_____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Name of Insured if other than patient: _____ DOB: _____

Relationship to patient: _____ SS#: _____

MEDICATION REFILL POLICY: Please call your pharmacy directly for refills. They will contact us for approval. Allow 36 hours to process your refill. Additional time may be needed if your insurance company requires pre-authorization. We will file your mail order pharmacy as a courtesy to you. It is the patient's responsibility to keep the medication list current and notify us of any changes made by other physicians.

CHANGE OR CANCEL APPOINTMENT: To avoid a no-show fee of $50.00, call the office in advance to reschedule or cancel an appointment. Same day cancellations and same day request for rescheduling are considered no shows and the $50.00 fee will apply.

Medical Release & Assignment of Benefits

Date: _____

Name: _____ DOB: _____

I authorized the release of medical information necessary to process payment for services rendered. I authorize Dr. Hernandez to submit claims to my medical insurance on my behalf for services rendered by him. I request that insurance payment be made directly to Dr. Hernandez. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

I understand that I am responsible for payment of any services rendered to me or my dependent(s) provided by this office. I understand that I am responsible for any service my insurance plan deems non-covered, all coinsurance, co-payments, deductibles, and any amount that exceeds benefits.

Signature:_____ Date: _____

I acknowledge having received this office's NOTICE OF PRIVACY PRACTICES explaining how my medical information will be used or disclosed.

Signature: _____ Date:_____

****

MY MEDICAL INFORMATION MAY BE RELEASED TO THE FOLLOWING FAMILY MEMBERS

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

AUTHORIZATION FOR RELEASE OF INFORMATION

*Patient's Name: _____ *DOB ____/____/____ SSN: _____

*Address:_____ *Telephone: _____

I authorize the facility named below to release information from my or the patient's health records to the facility or person indicated. I understand any treatment or payment for that treatment is not dependent on my signing of this release. I understand I may receive a copy of this release form if I desire one.

To be released by:

_____

_____

_____

_____

*To be released to:

David S. Hernandez, M.D.

1619 E. Common St., Suite 902

New Braunfels, TX 78130

Tel: (830) 214.0104 Fax: (830) 358.7371

*List date(s) or treatment to be released:

_____

***The information to be released from each visit is limited to:**

[ ] Lab test
[ ] Last PFT
[ ] Overnight Pulse Ox
[ ] Other (specify)

[ ] Last Sleep Study
[ ] Last CT
[ ] Last (2) Doctor's Notes

[ ] Demographics
[ ] 6 Minute Walk
[ ] Last X-ray

_____

* **The information is being released for the following purpose:**

[ ] Continued medical evaluation, Appt. Date _____
[ ] Personal use (fees apply)
[ ] Other (specify)

[ ]Third party payment/insurance (fees apply)
[ ] Legal consultation (fees apply)

_____

Any other use of release to another party without the written permission of the patient or the patient's authorized agent is Prohibited. However, I understand that no guarantee as to the confidentiality of this information can be made once it is released I understand that this authorization may be revoked at any time in writing, except to the extent that information has already been released and that revocation should be sent to the above entity at the above address. I hereby release any individual or organization disclosing the information contained in this patient's record from any liability if performed within the limits of this authorization. Unless revoked earlier, this release will expire on _____(Optional), or, if not specified, ninety (90) days from date signed.

***I understand that my records may contain information protected under State & Federal privacy laws including results of HIV testing or treatment and/or information regarding drug, alcohol or psychiatric treatment & I especially authorize the release of this information to the above-named recipient. Yes_____(initial) or No _____(initial).**

***_____ Signature of Patient or Legal Representative**

***_____ Date**

***_____ Relationship of Above Signer if Other Than Patient**

***_____ Witness Signature**

***Denotes Required Elements. This form must be completely filled out to be valid.**

Name: _____ Date: _____

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0 = no chance of dozing, to 3 = high chance of dozing. When you finish the test, add up the value of your response. Your total is based on a scale of 0-24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How sleepy are you?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tires. Even if you have done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- **No chance of dozing = 0**
- **Slight chance of dozing = 1**
- **Moderate chance of dozing = 2**
- **High chance of dozing = 3**

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and Reading	•
Watching TV	•
Sitting inactive in a public place (ex: a theater 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 lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score: _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15 You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

15-24 You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness; The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5

Patient Portal Agreement

Name:_____

Email:_____

Purpose of this Form

David S. Hernandez, MD PA offers secure electronic access to your medical records and secure communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable tool, but certain precautions should be used to minimize risk. In order to manage these risks, we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal works

A secure web portal is a webpage that uses encrypted information to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log into the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to participate

Once you have reviewed and agreed to and signed our policies and procedures regarding the use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal through our website at http://davidshernandez.com or by clicking here.

Protecting your Private Health Information and risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on many factors yet the secure message must reach the correct email address and the only individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information.

Conditions on participating in the Patient Portal

Access to the secure web portal is a service and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service, we will notify you as promptly as we reasonably can. You agree to not hold David S. Hernandez, MD PA or any of its staff or physician liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedures, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password.

If you have questions, we will gladly provide more information.

Patient Acknowledgement

Signature: _____

Date: _____

For Office Use Only

I have authenticated the identity of the person named on this authorization form:

- Picture ID
- Persons known to me
- Other (specify): _____

Employee Signature _____ Date _____

David S. Hernandez, M.D., P.A.

Financial Policy Practices

PLEASE READ CAREFULLY

Payment
Please be aware of your responsibility to call your insurance company and find out about your coverage and benefits. Some insurance require a Referral or Pre-authorization prior to the service**. If a Referral or Pre-authorization is required please obtain it prior to scheduling an appointment**. Find out from your insurance company if you are required to pay a co-pay/deductible. **A co-pay or deductible is due at the time of visit**. It is your responsibility to ensure your visit will be covered by your insurance. Should you find out a certain service is not covered, payment for that service will be due at time of service.

Billing Insurance
This office will bill the insurance for you, but it is your responsibility to call the insurance company and ask if Dr. Hernandez is contracted with them and what your co-pay and deductible is and if a Pre-authorization is needed. The reason you are asked to call your insurance is because there are numerous insurance companies each offering different benefits to its clients. It is this office's goal to provide you with the best medical service possible in a timely manner; therefore, we are asking you to come prepared with your insurance information to avoid any delays in verifying insurance coverage.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our Financial Policy Practices.

Change or Cancel Appointment
To avoid a no-show fee of $50.00, call the office 24 hours in advance to reschedule or cancel an appointment. Same day cancellations and same day request for rescheduling are considered no shows and the $50.00 fee will apply.

Documents Requiring Completion and Signature
Application for Persons with Disabilities Parking Placard and/or License Plate, letters, forms, any type of document requiring completion and signature of a Licensed Medical Professional will be processed for a fee of $45.00

I have read and understand this office's Financial Policy Practices and agree to be bound by them.

_____ _____
Signature of Patient (or parent or guardian) Date

_____
Name of Patient (Print)

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