

METROPLEX PULMONARY & SLEEP CENTER, P.A
 4833 Medical Center Drive, Suite 6B McKinney, Texas 75069
 Phone: 972-838-1892 Fax: 972-838-1896 or 972-954-6030

PATIENT HISTORY FORM			
Name: (Please print)			
Date of birth		Age:	
Describe the current medical problem or reason for today's visit:			
Have you had any recent CT Scans, x-rays or lab tests , relating to this problem? Yes No			
If yes, when and where were those done?			
Who is your primary care physician?			
Who is your referring physician for today's visit?			
Have you ever been diagnosed with the following?			
asthma	heart attack	sleep apnea	thyroid disease
chronic bronchitis	stroke	kidney disease	high cholesterol
emphysema	hypertension	gastric ulcers	congestive heart
pneumonia	diabetes	hepatitis	tuberculosis
Past Surgical History (If you have a list we can make a copy):			
Other Hospitalizations:			
Are you allergic to any medications? Yes No			
If yes please write the name of the Medication(s)			
Current Medications: Please list all medications you are currently taking. We can also make a copy of your medication list if you have it with you.			
Are you using: Oxygen		CPAP	Nebulizer
Do you smoke (current smoker)? Yes No		if yes- how many packs a day?	
Ex-smoker:	Number of years smoked	how many packs per day?	
Do you consume alcohol on a regular basis?		Yes No	If yes-how much?
Do you have any history of family diseases?			
Have you ever had the flu vaccine? Yes No			
Have you ever had the pneumonia vaccine? Yes No			
Occupation:			
Are you married? Yes No		Do you have any children? Yes No	
Do you have pets at home? Yes No			
Have you been exposed to dust, fumes, or asbestos? Yes No			
Do you snore? Yes No			
Do you stop breathing at night? Yes No			
Do you have difficulty falling asleep? Yes No			
Do you have difficulty staying asleep? Yes No			
What time do you go to bed?		And wake up?	
Time you usually fall asleep?		Number of times you wake up at night?	
Signature of Patient:			Date:

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Do you sleep walk? Yes No	Do you talk while sleeping? Yes No
Do you sweat at night? Yes No	Do you have nightmares/abnormal dreams?
Do you feel tired in the morning? Yes No	
Do you have difficulty staying awake during the daytime? Yes No	
Do you have restless leg symptoms? Yes No	Do your legs ache at night? Yes No
Do you feel muscle weakness while laughing or crying? Yes No	
Do you have: Fevers chills	Do you sweat at night?
Do you get short of breath? Yes No with exertion (exercise) Yes No	
When did you first notice shortness of breath? Days Weeks Months Years	
Has the shortness of breath gotten worse over time? Yes No	
If so, has it gotten worse: slowly suddenly	
If so, how much exertion does it take: (circle all that apply?)	
a) walking slowly	b) walking quickly
c) climbing up a slope/ hill	d) climbing stairs
Does anything else make you short of breath?	
Do you wake up at night short of breath? Yes No	
Do your feet swell? Yes No	
Do you feel shortness of breath when you first lie down at night? Yes No	
When lying down do you prop your head up to breath comfortably? Yes No	
Do you wake up wheezing at night? Yes No	
Do you cough? Yes No	How long have you been coughing for?
Does anything cause you to cough or worsen it?	
Is cough worse at certain times of the day?	
Is cough worse at night?	Does it wake you up at night?
Do you bring up sputum? Yes No	
What color is your sputum: Circle one: clear, white, gray, yellow, and green	
On average how much sputum do you cough up during a day?	
Have you ever noticed blood in your sputum? Yes No	
Do you have pain/discomfort in your chest? Yes No	If so, what area of chest?
What type of pain: a) sharp	b) dull
c) stabbing	d) constant
e) intermittent	
Does pain shift to another part of your body? Yes No	
Is pain worse with exercise? Yes No	
Is pain worse with deep breathing? Yes No	
Do you wheeze? Yes No	What makes you wheeze?
Have you ever been exposed to Tuberculosis? Yes No	
Do you suffer from: headaches	seizures
passing out spells	dizziness
Do you experience: nausea	vomiting
diarrhea	reflux
Do you experience: arthritis	
muscle aches	
Did you notice: weight loss	weight Gain
fatigue	
Print Patient's Name:	
Signature of Patient:	Date:

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Patient Registration		
Name: (please print)		Date of birth:
Address:		State: Zip:
Email address:		
Cell phone #:	Home Phone #	Work Phone#
Marital status:	Spouse's name:	
SS#: Employer:		
Emergency contact name: (Please print)		Phone #
Relation:		
Which is the best number to contact you?		
Can we leave a message on your voice mail? Yes		No
You can request your medical records to be mailed to your house. We will send those to you by USPS Certified mail and with signature confirmation. However, you must send us a written and signed request if you wish to receive your medical records via email.		
Who do you authorize to talk to us on your behalf in your absence? Name:		
Relation:		
Your Pharmacy's name:		Phone number
Your oxygen and/or CPAP machine supplier's name:		Phone number
INSURANCE INFORMATION		
Primary Insurance Company:		
Name of insured:		
Group #:	ID #:	
Secondary/Supplemental Insurance:		
Name of Insured:		
Group #:	ID #	
Tertiary/Supplemental Insurance:		
Name of Insured:		
Group#:	ID #:	
ASSIGNMENT OF INSURANCE BENEFITS		
I request that payment of authorized insurance benefits be made on my behalf to Metroplex Pulmonary and Sleep Center for any services furnished by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.		
Signature of Patient:		
Or Authorized Representative:		
Date:		

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Metroplex Pulmonary and Sleep Center provided me with a written copy its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature

Date

Personal Representative Signature (if applicable)

Relationship to Patient

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Sleep and breathing disorders are extremely common in this country and affect daytime wakefulness to different degree in each person. Obviously, each person must use his or her best judgement to be safe during operating heavy machinery, behind the wheel or working at heights. Furthermore, you should also be aware that sleep medications may cause daytime drowsiness as well. Therefore, you should not expose yourself to others to avoid possible harm due to potential drowsiness.

For your protection we require that you have received this notice. Therefore, please sign below.

Signature of Patient: _____ **Date:** _____

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Patient is responsible for the services/provided charges if insurance does not cover.

It is necessary for our office to enact the following policies effective January of each year due to the increase in high deductibles, co-insurance portions, co-payments of insurance companies' pending claims and withholding payments. Please feel free to ask for clarification if necessary.

Your office visit, PFT Pulmonary Function (breathing) Test, sleep study take home device, Labs (orders sent out), CPAP, or CPAP Supplies and Spirometry might not be paid by your insurance. I hereby give authorization to Dr. Shahrukh Kureishy/Dr. Ferzana Mir and their staff to provide medical treatment. I understand that no guarantees have been made with regards to treatment success, and that there may be complications associated with the condition or with its proposed treatment. By signing below you are agreeing to pay for these services yourself, even if those are determined by your insurance as not to be "medically necessary."

We ask for your insurance information when we schedule your first appointment, and we make every effort to verify your benefits for procedures that are common in our practice. While we do our best to verify that our doctors are contracted and in network with your insurance plan, it is ultimately your responsibility that this is the case. Based upon information provided to us by your insurance company we will expect payment according to the benefits quoted. Your copayment, co-insurance or deductible per your insurance company, and as indicated on most insurance cards will be collected before seeing the doctor. We will then file your office visit superbill with your insurance company. However, you will be responsible for your portion after your insurance pays, and as it indicates on your EOB. Also, we will not be held responsible if you or your accompanied person/s falls and injures in or outside our office. Any outstanding balance will be due and payable upon receipt of the statement. Many insurance plans have a requirement that patients must provide additional information to them before they will pay your claim. When this is the case, your insurance company will inform us that they have "pending" your claim for additional information. If that happens, the full balance due on your visit becomes your responsibility. Once an insurance company "pends" a claim, there is nothing that our office can do to get the claim paid. It is completely your responsibility to contact your insurance company to provide them the needed information so your insurance company pays the claim within 30 days. Additionally, you must notify us at the time of service if your insurance plan, group, or policy number changes so we can file your claim precisely.

Visits that have been filed by us in a timely manner but denied by your insurance after 60 days will become your responsibility. Please remember that our office files to your insurance as a courtesy to you. It is important to remember that your insurance policy is a contract between you and the insurance company.

I also understand that failure to appear on scheduled follow up or new patient visit appointment may result in a delay in the diagnosis, and treatment of a potentially serious condition. We call in advance to remind an upcoming appointment, and/or reschedule if the appointment cannot be kept. However, we will not be held responsible for complications arising from missed appointments due to the patient's noncompliance.

We reserve the right to charge \$35 for missed appointment and no show not given (24 hours' notice by the patient.) Returned checks for insufficient funds will be subjected to \$35 fees as well. Payment is expected at the time of service.

Signature of Patient: _____

Patient's Printed Name: _____

Responsible person's name if patient is unable to sign: (please print) _____

Responsible Person's signature: _____

Relation with the patient: _____

Date: _____