



**METROPLEX PULMONARY & SLEEP CENTER, P.A.**  
**Shahrukh A. Kureishy M.D., F.C.C.P.**  
 Board Certified in: Pulmonary, Critical Care, and Sleep Medicine

Registration Information:

Patient Last Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Apt/Unit No. Sex \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Emergency Contact/Phone: \_\_\_\_\_ Driver's License: \_\_\_\_\_  
 Primary/Referring Physician/Phone: \_\_\_\_\_

Employer Name : \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 \_\_\_\_\_ Email: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Contact: \_\_\_\_\_

*Provide the following information if guarantor is different than patient*

Guarantor Last Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Patient's Relationship to Guarantor: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

<i>Primary Insurance- circle</i>	<i>PPO</i>	<i>HMO</i>	<i>Other</i>	<i>Don't Know</i>	<i>Secondary Insurance- circle</i>	<i>PPO</i>	<i>HMO</i>	<i>Other</i>	<i>Don't Know</i>
Company Name: _____					Company Name: _____				
Plan/Network Name: _____					Plan/Network Name: _____				
Claims Address: _____					Claims Address: _____				
City: _____ State: _____ Zip: _____					City: _____ State: _____ Zip: _____				
Phone: _____ Fax: _____					Phone: _____ Fax: _____				
Policy/ID#: _____ Group#: _____					Policy/ID#: _____ Group#: _____				
Insured Name: _____					Insured Name: _____				
Address: _____					Address: _____				
City: _____ State: _____ Zip: _____					City: _____ State: _____ Zip: _____				
Phone: _____ DOB: _____ Sex: _____					Phone: _____ DOB: _____ Sex: _____				
Insured Employer: _____					Insured Employer: _____				
Address: _____					Address: _____				
Phone: _____ Fax: _____					Phone: _____ Fax: _____				
Patient's Relationship to Insured: _____					Patient's Relationship to Insured: _____				

Authorization for Treatment and Insurance Authorization:

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I permit **Metroplex Pulmonary and Sleep Center** to administer necessary and advisable diagnosis and treatment to me. I am aware that medicine is not an exact science and no guarantees have been made as to the results of the treatment and examinations.

I hereby authorize **Metroplex Pulmonary and Sleep Center** to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to **Metroplex Pulmonary and Sleep Center**, (or to the party who accepts assignments). Our office files insurance claims as a courtesy and in no way releases the patient from responsibility of his/her bill. By signing below the patient agrees to accept responsibility for his/her bill in the event that insurance denies or partially pays for the claim. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date \_\_\_\_\_ Signature \_\_\_\_\_



HOW CAN WE GET IN CONTACT WITH YOU? \_\_\_\_\_  
 LEAVE A MESSAGE ON HOME PH OR WORK PH? \_\_\_\_\_  
 TALK TO SPOUSE YES OR NO. \_\_\_\_\_  
 LEAVE A MESSAGE ON CELL PHONE? \_\_\_\_\_  
 WE NEED YOU TO COME UP WITH A PASSWORD. \_\_\_\_\_  
 YOUR PHARMACY AND THEIR NUMBER. \_\_\_\_\_  
 YOUR PRIMARY CARE PHYSICIAN AND WHAT IS THEIR NUMBER \_\_\_\_\_  
 \_\_\_\_\_  
 YOUR OXYGEN AND/OR CPAP MACHINE SUPPLIER AND THEIR NUMBER? \_\_\_\_\_

Dear Patient,

Sleep problems are extremely common. Breathing disorders of sleep alone affects 4% of women and 9% of men between the ages of 30 and 60 in this country. Insomnia may be present in 15 to 20 percent of the population on a chronic basis. All of these disorders affect daytime wakefulness to different degree in each person. For instance, some people with moderately severe apnea claim to have little or no symptoms of daytime fatigue, while some individuals who only manifest snoring during sleep may feel terribly sleepy during the day.

Obviously, each person must use his or her best judgment to determine if placing himself or herself in a particular setting/situation (for example: driving a car, using heavy machinery, or working at heights) which might lead to them harming himself, herself or others.

**YOU SHOULD BE AWARE THAT ANY NIGHTTIME SLEEP DISTURBANCE MAY CAUSE DAYTIME DROWSINESS AND THEREFORE COULD IMPAIR YOUR ABILITY TO OPERATE HEAVY MACHINERY (ESPECIALLY A MOTOR VEHICLE.) YOU SHOULD NOT EXPOSE YOURSELF TO OTHERS TO HARM BECAUSE OF YOUR POTENTIAL DROWSINESS.**

For your protection we require verification that you have received this notice. Therefore, please sign below and bring with you to your appointment.

Thank you!  
 PATIENT SIGNATURE

DATE

\_\_\_\_\_

\_\_\_\_\_



**MEDICAL RECORDS RELEASE FORM**

I \_\_\_\_\_ authorize the release of information regarding my medical records to the below listed names/facilities/physicians. I have been informed of my HIPPA rights and understand this is necessary to protect my rights.

Name/Facility/Physician Name

Relationship (of applicable)

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\_\_\_\_\_  
Patients Name (Print)

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Patient Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness