Millennium Physicians
Respiratory & Sleep Disorder Specialists

Today's Date_____

NEW PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Social Security No _____ Male / Female (circle)

Street Address _____

City/State/Zip _____ Student? YES NO

Occupation _____ Marital Status _____

Cell Phone (preferred) _____ Alternate Phone (cell/work/home) _____

Email address _____

The HIPAA privacy rule gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual also has the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to individual's office instead of the individual's home. **I wish to be contacted in the following manner (check all that apply):**

☐ Cell Phone ☐ Work Phone ☐ Home Phone ☐ Mail address:_____

EMERGENCY CONTACT & MEDICAL RECORD ACCESS

In addition to being my emergency contact(s), I authorize RSDS to communicate with the individual(s) listed below regarding any medical and/or financial issues. The privacy rule also allows for a patient to allow certain people to have access to their records, per patient's written allowance. Please specify which contacts are allowed this access to your medical records.

Name	Relationship	Contact cell #	Allow record access?
			YES or NO
			YES or NO
			YES or NO

RESPONSIBLE PARTY / GUARANTOR

If same as patient, skip this section

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Relation to Patient _____

Street Address _____

City/State/Zip _____

Cell Phone (preferred) _____ Alternate Phone (cell/work/home) _____

Email address _____

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REFERRAL / CONTINUITY OF CARE

REFERRING DOCTOR _____ **PRIMARY CARE DOCTOR** _____

Other Specialists Involved in your Care (List name and specialty - Cardiologist, Oncologist, etc…)	

INSURANCE INFORMATION		
	Primary Insurance	**Secondary Insurance**
Insurance Name		
Name of Policy Holder		
SSN of Policy Holder		
Relation to Patient		
Employer		
Policy or ID Number		
Group Number		
PHARMACY INFORMATION		
Local Pharmacy	Name:	Phone #
Mail Order Pharmacy	Name:	Phone #

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above & assign directly to RSDS all my 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 my insurance. I hereby authorize the use of this signature of all insurance submissions. I have received, read, & understand all documents given to me in regard to HIPAA rights as a patient. If patient is a minor, _____ (parent/guardian) consent to minor's evaluation and treatment.

Signature: _____ Date: _____

Parent/Guardian signature if patient is a minor:_____ Date:_____

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Acknowledgement of Receipt, Notice of Privacy Information Practices

I,_____ acknowledge and agree that I have received a copy of the Notice of Privacy Practices for Millennium RSDS.

Signature:_____ **Date:**_____

If patient did not sign, Millennium RSDS gave good efforts to obtain the above referenced individuals written acknowledgement of receipt of Notice of Privacy Practices. (Identify the efforts that were made to obtain the individuals written acknowledgement, including the reasons (if known) why written acknowledgement was not obtained)

_____

No Show/Cancellation Policy

If you cancel your appointment with less than 24 hours' notice, this is a no show appointment and you could be charged a fee of $35 that will be payable before you can reschedule your appointment. This will not be covered by your insurance.

Initials_____

Sleep Study No Show/Cancellation Policy

If you cancel your sleep study with less than 24 hours' notice, or by Friday morning, for Saturday or Sunday night; you could be charged a $200 fee which is the cost we pay to reserve the technician for the sleep study. This will be payable before your next sleep study will be rescheduled. To cancel your sleep study, please call 281-296-8788, ext 7529.

Thank you, Lash Wright, Sleep Center Manager lawright@mphcc.com

Initials_____

Patient Portal Policy

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communication between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information.

Patient name printed:_____ Date of Birth:_____

Email address:_____

Signature:_____ _____ _____
Relationship Date

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PATIENT HISTORY

1 Why are you here to see the doctor today?

_____

_____

_____

2 Do you currently have or suffer from any of the following:

☐ Shortness of breath	☐ COPD/Emphysema/Bronchitis	☐ Asthma
☐ Cough	☐ Lung cancer	☐ Pulmonary embolism/DVT
☐ Coughing up blood	☐ Pulmonary Nodule	☐ Bronchiectasis or MAC/MAI
☐ Snoring/Sleep Apnea	☐ Other cancer _____	☐ Unexplained weight loss
☐ Insomnia	☐ Chest pain or pressure	☐ Fever or chills
☐ Other sleep issue	☐ Heart disease	☐ Tuberculosis or +PPD
☐ GERD/Reflux	☐ Heart failure	☐ Allergic rhinitis
☐ Hoarseness	☐ Arrhythmia	☐ Rash

Other: (please list any and all medical problems you have that are not listed above)

_____

_____

_____

3 What **surgeries or operations** have you had and **when?**

_____

_____

4 Have you **had imaging (CXR, CT scan, echocardiogram, etc**) done? If yes, **where and when?**

_____

_____

5 Have you been **hospitalized** recently or seen in an **ED or urgent care**, if so **where and when?**

_____

6 Do you suffer from **snoring, waking up gasping, witnessed choking episodes, excessive sleepiness and/or fatigue? YES NO**

7 Do you suffer from **insomnia, or an inability to fall asleep or stay asleep? YES NO**

8 Do you have **uncontrollable sleep attacks, or brief episodes of loss of muscle tone and function YES NO**

9 Any other unwanted behaviors during sleep? _____

Patient name: _____

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10 **How likely are you to fall asleep in the following situations?**				
Sitting and reading	____ Never	____ Slight	____Moderate	____ High
Watching television	____ Never	____ Slight	____Moderate	____ High
Sitting inactive in a public place	____ Never	____ Slight	____Moderate	____ High
As a passenger in a car for more than 1 hour	____ Never	____ Slight	____Moderate	____ High
Lying down to rest in the afternoon	____ Never	____ Slight	____Moderate	____ High
Sitting and talking to someone	____ Never	____ Slight	____Moderate	____ High
Sitting quietly after lunch	____ Never	____ Slight	____Moderate	____ High
In a car stopped at a traffic light	____ Never	____ Slight	____Moderate	____ High
				_____

11 **Vaccine Status**	
Flu Vaccine? **YES NO Date:**	Pneumonia Vaccine? **YES NO Date:**
Covid Vaccine? **YES NO Date:**	If yes to above: Prevnar 13 or Pneumovax 23?

12 **Oxygen / Sleep Apnea**	
Oxygen? **YES NO** Flow rate: _____ lpm	CPAP/BiPAP? **YES NO** Pressure: _____
Last sleep study date:	Location of last sleep study:
DME Company name (for CPAP or home Oxygen):	

13 **Substance Use**	
Do you smoke? **YES NO**	If YES, how many packs/day?
How many years did you smoke?	If you quit smoking, when did you quit?
Do you vape or e-cig? **YES NO**	Recreational drug use? **YES NO**
How much alcohol do you drink?	

14 Are there any other issues you would like to address with the doctor today?

_____

_____

_____

_____

Patient name: _____

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MEDICATION LOG			
Medication Name	**Dosage**	**Frequency**	**Prescribing MD**

Are you allergic to any medications?	
Medication	**Reaction**

Patient name: _____

Wael Asi, M.D., P.A.
Jefy Mathew, M.D.
Ather Siddiqi, M.D.
William Rhoton, M.D.
Ariffin Alam, MD

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Hammad Qureshi, M.D.
Salah Fares, M.D.
Amarbir Mattewal, M.D.
Mohsin Bajwa, M.D.
Amrew Al-Ahmad, MD
Humberto C. Sasieta, MD

Authorization for Disclosure of Confidential Information

Patient Name: _____

Date of Birth: _____ *SSN:* _____

Street Address: _____

I hereby authorize Respiratory and Sleep Disorder Specialists to:

Release to: _____ *Receive from:* _____

Name of Person/ Facility: _____

Street Address: _____

City, State, Zip: _____

Phone/Fax: _____

Please fax records to 281-419-1291

_____**History & Physical**	_____**Discharge Summary**	_____**PFT**
_____ **Progress Notes**	_____**Sleep studies**	_____**Lab Results**
_____ **Pathology Results**	_____**Radiology Reports**	_____**Other:**_____

This authorization covers patient care given from _____ to _____.

Purpose of Disclosure: _____Medical Care _____ Attorney _____Insurance _____Other

I understand that I may revoke this authorization in writing at any time, except to the extent that the action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state regulations.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____