Patient Registration Form

Name: _____ DOB: _____

Address: _____
(Street) (City) (State) (Zip)

Preferred method of contacting you: Home # Cell # Work# Email

Phone: H_____ W_____ C_____

Email Address: _____ SSN_____

Primary Care Physician_____ Phone _____

Preferred Pharmacy_____ Address_____

Emergency Contact:_____
(Name) (Relationship) (Phone Number)

Current Insurance Information is:

Primary_____
(Ins. Co. Name) (ID#) (Grp#) (SSN#)

_____
(Policy Holder Name) (DOB) (Patient Relation)

_____
(Ins. Co. Address) (Ins. Co. Phone)

Secondary_____
(Ins. Co. Name) (ID#) (Grp#)

_____
(Policy Holder Name) (DOB) (Patient Relation)

_____
(Ins. Co. Address) (Ins. Co. Phone)

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

_____ Date: _____
Patient Signature

NEW PATIENT QUESTIONAIRE

NAME_____**DATE OF BIRTH**_____

NAME & PHONE NUMBER OF REFERRING PHYSICIAN _____

NAME & PHONE NUMBER OF PRIMARY CARE PHYSICIAN _____

WHAT IS THE PROBLEM FOR WHICH YOU ARE SEEING US TODAY? (Please check all that apply)

_____**Shortness of breath** _____

_____**Cough** _____

_____**Abnormal Chest X-Ray** _____

_____**Abnormal CT Scan** _____

_____**Pre-operative Evaluation** _____

_____**Sleep Apnea** _____

_____**Asthma**

_____**Wheezing/COPD/Bronchitis** _____

_____**Chest Pain/Tightness** _____

_____**Pneumonia** _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING, BOTH REGULAR MEDS AND "AS NEEDED" MEDS. PLEASE INCLUDE INHALERS, CREAMS, DROPS, & SUPPLEMENTS. *PLEASE LIST THE NAME, STRENGTH, DOSE, AND FREQUENCY (HOW OFTEN YOU TAKE IT)—See the examples, and list your meds in a similar fashion*---You can use the back of this page as well if you run out of spaces

	DRUG NAME	STRENGTH	DOSE	FREQUENCY
EXAMPLE	Furosemide	40 mg	1 tablet	Twice a day
EXAMPLE	Symbicort	160/4.5	2 puffs	Twice a day
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

PLEASE LIST ANY CURRENT AND PAST MEDICAL PROBLEMS FOR WHICH YOU HAVE RECEIVED TREATMENT (Ex: Shortness of Breath, Asthma, COPD, Pneumonia, Heart Conditions, etc.) LIST SURGERIES IN NEXT SECTION.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PLEASE LIST ANY SURGERY YOU HAVE HAD IN THE PAST AND THE APPROXIMATE YEAR THAT THE SURGERY WAS DONE---Please list them from most recent to most distant.

	YEAR	SURGICAL PROCEDURES
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PLEASE LIST ANY ALLERGIES TO MEDICATIONS AND THE SPECIFIC REACTION YOU HAD TO THAT DRUG (Rash, trouble breathing, etc.)

	DRUG NAME	REACTION
1.		
2.		
3.		
4.		

FAMILY HISTORY

Mother: Living____ Age____ Deceased___ Age at death_____
General Health_____ Cause of death_____

Father: Living____ Age____ Deceased____ Age at death_____
General Health_____ Cause of death_____

***Brothers & Sisters*:** LIVING DECEASED

Age:____ M/F____ Health_____ Age:____ Cause_____
Age:____ M/F____ Health_____ Age:____ Cause_____
Age:____ M/F____ Health_____ Age:____ Cause_____
Age:____ M/F____ Health_____ Age:____ Cause_____
Age:____ M/F____ Health_____ Age:____ Cause_____

How many children do you have?

	SON	DAUGHTER
How Many		
Age		
Healthy		
Medical Problem		

If any of your BLOOD relatives have any of these conditions, please check and list their relationship to you:

___Asthma
___Emphysema
___Diabetes
___High Blood Pressure
___Cancer
___Blood Clots
___Chronic Bronchitis
___Allergies
___Heart Disease
___Stroke
___Tuberculosis
___Cystic Fibrosis

SOCIAL HISTORY

Marital status:

_____Single _____Married _____Partnered
_____Divorced _____Separated _____Widowed

Smoking Status:

_____Never Smoked _____Former Smoker _____Current Smoker

If you quit smoking, what month and year did you quit? _____

If you currently smoke or have smoked in the past, how much did you smoke?

_____Average number of packs per day _____Number of years

Alcohol/Drug Use:

Do you drink alcohol? _____None _____Rarely _____Socially
_____Daily (if daily, how many drinks per day? _____)

Do you or have you used recreational/illegal drugs? _____
If so, what have you used? _____

Occupation:

Are you currently: _____Employed _____Self Employed _____Retired
_____Homemaker _____Student _____Unemployed

Please list all jobs from most recent to most distant:

	YEARS WORKED	JOB DESCRIPTION
1.		
2.		
3.		
4.		
5.		
6.		

Have you been exposed to toxic agents at work (asbestos, radiation, chemicals)? ___Yes ___No

REVIEW OF SYSTEMS

Please note any symptoms or conditions you are experiencing:

General

___Yes ___No--Anxiety

___Yes ___No--Chills

___Yes ___No--Fever

___Yes ___No--Night Sweats

___Yes ___No--Fatigue

___Yes ___No--Weakness

___Yes ___No--Loss of Appetite

___Yes ___No--Weight Gain
If yes how much _____

___Yes ___No--Weight Loss
If yes how much _____

Eyes

___Yes ___No--Blurred vision

___Yes ___No--Diminished vision

___Yes ___No--Loss of vision

___Yes ___No--Cataracts

___Yes ___No--Eye irritation

Ears

___Yes ___No--Decreased hearing

___Yes ___No--Loss of hearing

___Yes ___No--Ringing in ears

___Yes ___No--Discharge from ears

___Yes ___No --Ear pain

Nose/Throat

___Yes ___No--Sinus problems

___Yes ___No--Seasonal Allergies

___Yes ___No--Sinus pain

___Yes ___No --Sinus drainage

___Yes ___No--Nasal Congestion

___Yes ___No--Frequent nosebleeds

___Yes ___No--Sore throat

___Yes ___No--Trouble swallowing

___Yes ___No--Change in voice

Cardiovascular

___Yes___No--Chest pain

___Yes___No--Irregular heart beat

___Yes___No--Chest tightness

___Yes___No--Palpitations

___Yes___No--Murmur

___Yes___No--Leg swelling

___Yes___No--Leg pain with walking

___Yes___No--Clots in the legs

Gastrointestinal

___Yes___No--Nausea

___Yes___No--Vomiting

___Yes___No--Diarrhea

___Yes___No--Constipation

___Yes___No--Changed bowel habits

___Yes___No--Heartburn

___Yes___No--Blood in stool

___Yes___No--Dark tarry stools

___Yes___No--Abdominal pain

Musculoskeletal

___Yes___No--Arthritis

___Yes___No--Joint pain

___Yes___No--Joint stiffness

___Yes___No—Joint swelling

___Yes___No--Muscle aches

___Yes___No--Back pain

___Yes___No--Osteoporosis

___Yes___No--Fracture

___Yes___No--Carpal tunnel

___Yes___No--Sciatica

Neurological

___Yes___No--Headache

___Yes___No--Memory loss

___Yes___No--Seizures

___Yes___No--Gait abnormality

___Yes___No--Dizziness

___Yes___No--Fainting spells

___Yes___No--Tremors

___Yes___No--Tingling

___Yes___No--Numbness

Urological

___Yes___No--Blood in urine

___Yes___No--Kidney stones

___Yes___No--Difficulty urinating

___Yes___No--Frequent urination

___Yes___No--Nocturnal urination

___Yes___No--Urinary infections

___Yes___No--Incontinence

Have you travelled anywhere outside the United States in the last 3 years? If so, where?

_____

_____

Please list any pets and if they are outdoor or indoor:

_____

_____

Are you on any special diet? If so, what kind?

_____

Do you exercise regularly? If so, describe below:

Type:_____ Duration:_____min

Frequency:_____times per week

THE ABOVE INFORMATION WAS FILLED OUT BY:

_____Patient _____Other (please note your relation)_____

Signature_____Date_____

MALLADI R. SASTRY, M.D.
PULMONARY AND CRITICAL CARE MEDICINE
4100 W. 15TH STREET, SUITE 216
PLANO, TX 75093
PHONE: 972-596-2135
FAX: 972-596-7382

Effective 01-01-17

Cancellation Policy/No Show Policy For Doctor Appointments

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.
If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. *Account balances*

We will require that patients with self-pay balances do pay their account balances to zero ($0) prior to receiving further services by our practice. If you have questions about your bills or who would like to discuss a payment plan option may call and ask to speak with our business office representative with whom they can review your account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ____/____/____
Patient Signature **Date**

Print Name _____

Authorization for Release of Medical Records

To: _____ Fax#: _____

Patients Name: _____ D.O.B.: _____

I have given authorization for any and all medical records describing my health history, symptoms, examinations, test results, diagnoses, treatments and any plans for future treatment to be released as follows:

_____ All of my medical records released.

_____Only the following: _____

_____

_____

_____

To: Malladi R. Sastry, M.D., P.A.

4100 W. 15th Street Suite 216
Plano, TX 75093
Phone: (972)596-2135
Fax: (972)596-2420

Thank you for your cooperation.

_____ _____
Patients Signature Date

_____ _____
Witness Date

PATIENT CONSENT FORM

I, as a patient of Dr. Malladi Sastry, understand that as a part of my health care that the practice originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for further care or treatment including referrals. I also understand that this information is utilized to plan for my care and treatment, to bill for services provided to me, and to communicate with other health care providers and other health care operations.

The Physicians Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy or access to the Notice of Privacy Practices and understand that I have a right to review the notice prior to signing this consent.

I understand that the physician reserves the right to change the Notice of Privacy practices and that I can request any changes be sent to me at the address listed below. I understand that I do have the right to restrict the use and/or disclosure of my personal health information and that the physician is not required to agree to treatment, payment or healthcare operations. I am free to revoke this consent anytime in writing.

I authorize the physician to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to the physician. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Please list below any restrictions on the use of personal health information:

I understand that any and all records whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provide by law.

This document serves as written consent based on the fact that I have been provided and have reviewed the Physician's Notice of Privacy Practices.

I voluntarily consent to the medical treatment and understand that no guarantees are made as to the results. I also give my consent to have my picture taken and placed in my medical record.

Signature **Date**

Malladi R. Sastry, M.D., P.A.
Pulmonary and Critical Care Medicine

PATIENT'S FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____

Date of Birth: _____

PLEASE INITIAL EACH PARAGRAPH AFTER READING AND SIGN THE BOTTOM

_____I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service visit, preventative exam, pulmonary function test (PFT), nebulization therapy, injections, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

_____I understand and agree it is **my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit**, preventative exam, and any other service ordered by the physician or the physician's staff. I also understand that I CAN refuse any service until further checking with my insurance to see if it is covered.

_____I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual customary limit, or any other benefit limitation for the services I receive, and agree to make full payment.

_____I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand and agree to be financially responsible and make full payment.

_____I understand that it is **my responsibility** to know if my insurance requires a referral from my primary care physician (PCP) in order for services to be covered for a specialist physician. If a referral is required I understand that **as the patient I must obtain the referral** and provide it to the specialist physician on or before my first visit to their office. If I DO NOT provide a needed referral to the specialist physician I understand that the services provided may not be covered or may result in a higher out of pocket cost to me, and I agree to be financially responsible and make full payment.

_____ If for some reason my insurance is out of network, and I was not aware, I agree to pay out my balance in full with payment plan.

Patient Signature: _____ **Date:** _____

Responsible Party Name (if minor): _____

Responsible Party Signature: _____