Patient Information (Please print clearly)

Name: ____ DOB: ______________

(Last) (First) (Middle) Sex: M F

Marital Status: S M D W Email: ______________________________

Home Phone #: ____________________ Cell Phone #: ______________________

Address: ________________________ City: __________ State: ______ Zip: ______

Emergency Contact

Name: ____

(Last) (First) (Middle)

Telephone: ______________________ Relationship: ______________________

Insurance Information

Primary Insurance Company: ____________________ Subscriber Name: ______________

SSN of Policy Holder: ________________________ Subscriber DOB: ______________

Policy ID #: ________________________________ Group#: ____________________

Secondary Insurance Company: __________________ Subscriber Name: ______________

SSN of Policy Holder: ________________________ Subscriber DOB: ______________

Policy ID #: ________________________________ Group #: ____________________

I authorize my physician to release any information in the course of my treatment or examination and permit payment directly to the provider at his election, any benefits due to me for medical services rendered. I recognize and accept responsibility for any balance that remains after payment of such benefits.

Patient's Signature : ____________________________________ Date: __________

Other Information

Primary Care Physician: __________________________ Telephone: ______________

Preferred Pharmacy: _____________________________ Telephone: ______________

Missed or Cancelled Appointments

As of May 1, 2006, all patients are required to give a 24 hours notice, for missed and/or cancelled appointments. An answering service is available at all times for your convenience.

You will be held solely responsible for payment of the missed/cancellation fee before another appointment can be scheduled. This fee may not and will not be covered by your insurance company.

If you are not compliant, Dr. Kayyas reserves the right to release you as a patient from our practice. **Three missed/cancelled appointments will result in being released from the practice.**

Missed/Cancellation Fees are assessed as follows:

$50-New Patient Appointment

$30-Allergy Testing Appointment

$30-Follow Up Appointment

$100-Sleep Study Appointment

Patient Signature: ____________________________________ **Date:** __________

Written Acknowledgement

I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information used and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Patient Name: ____

Patient Signature: ____ **Date:** ________________

Authorization To Discuss Protected Health Information

I, ______________________________________ authorize __________________________________ to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following:

1. ______________________________________ 2. ______________________________________

- Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information.
- You may change, restrict or expand this listing at any time.
- You are not required to list any name if you do not chose.

Patient Signature: ____ **Date:** ___________

Patient Name:_________________________________ **Date**______________________

Please indicate the reason for today's visit:

☐ Asthma ☐ COPD ☐ Sleep Evaluation
☐ Allergy ☐ Shortness of breath ☐ Abnormal X-Ray

Smoking History:

☐ Active smoker ☐ I smoke_____Pack Per Day ☐ Age started ______ ☐ Total years smoked_____

☐ Lifelong Non-Smoker ☐ Ex-Smoker, Quit date: _____ ☐ Second hand smoking

Do you or have you used ☐ Cigar ☐ Pipe ☐ Chew Tobacco

Allergies:

Are you allergic to any medications? Please List:____

Do you have pets? Please List: ____

Are you allergic to:

☐ Milk ☐ Eggs ☐ Nuts ☐ Mushrooms
☐ Strawberries ☐ Wheat ☐Seeds

Are you allergic to:

☐ Fish ____________ ☐ Shellfish ____________ ☐House Dust Mites ______________

Are you Allergic to:

☐Grass____________ ☐Trees____________ ☐Weeds____________ ☐ Fungus______________

Are you allergic to:

☐ Animal dander's______________________________ ☐ Insects:____

Please indicate if you have any of the following symptoms:

☐ Cough ☐ Nasal Congestion ☐ Chest Pain
☐ Wheezing ☐ Sinus Pressure ☐ Fever
☐ Bloody Sputum ☐ Nasal Bleed ☐ Other________________________

Please indicate if you have any of the following conditions:

☐ Allergic Rhinitis ☐ High Blood Pressure ☐ Anemia
☐ Seasonal Allergy ☐ Diabetes ☐ Ulcers
☐ Eczema/Hives ☐ High Cholesterol ☐ Reflux GERD
☐ Asthma ☐ Heart Attack ☐ Hepatitis A, B, C.
☐ Pneumonia ☐ Angioplasty/Stent ☐ Rheumatoid Arthritis
☐ COPD ☐ Heart Bypass ☐ Lupus
☐ Emphysema ☐ Congestive Heart Failure ☐ Seizure
☐ Lung Cancer ☐ Pacemaker ☐ Stroke
☐ Sarcoidosis ☐ Peripheral Artery Disease ☐ Alzheimer/Dementia
☐ Tuberculosis ☐ Kidney Failure/Disease ☐ Depression, Anxiety
☐ Blood Clots ☐ Thyroid Disease ☐ Osteoporosis
☐ Sleep Apnea ☐ Narcolepsy ☐ Restless Leg Syndrome
☐ Cancer:__________________ ☐ Other______________________ ☐______________________________

OBSTRUCTIVE SLEEP APNEA (OSA) RISK SCREENING TOOL

Pt Name: ____ **DOB:** _________

Patient presents with the following:

• I have been told I snore.	Yes	No
• I have been told that I quit breathing and/or choke during my sleep.	Yes	No
• I suffer from excessive daytime sleepiness.	Yes	No
• I am tired and/or experience fatigue throughout the day.	Yes	No
• I have nodded off or fallen asleep while driving a vehicle.	Yes	No
• I experience difficulty falling asleep or staying asleep.	Yes	No
• I still feel tired upon waking.	Yes	No
• I have morning headaches.	Yes	No
• My memory and/or concentration are impaired.	Yes	No
• I have high blood pressure.	Yes	No
• I am overweight, and/or I have gained weight recently.	Yes	No
• I experience anxiety, depression, and/or irritability.	Yes	No
• I am over 50 years old.	Yes	No

EPWORTH SLEEPINGESS SCALE

SITUATION	**CHANCE OF DOZING**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting, inactive in a public place (e.g. theater, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE:_______________