Respiratory & Sleep Specialists, LLC

PATIENT REGISTRATION FORM

Please complete this form to the best of your ability in order to ensure proper biling of your services. **Please Print.** Todays Date: _____

Patient Information

Patient Last Name: _____ First Name: _____MI: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other: _____

E-Mail: _____

Employer: _____ City, State, Zip: _____

Prefered Language: _____ Ethnicity: _____ Race: _____

Primary Care Information

Primary Care Physician: _____ Phone: _____

Referring Physician (If Different): _____ Phone: _____

Pharmacy Name, Address, Phone: _____

Emergency Contact / Next of Kin Information

Name: _____ Relation: _____

Phone Number: _____ Check those that apply: ☐ Emergency Contact ☐ Next of Kin

Name: _____ Relation: _____

Phone Number: _____ Check those that apply: ☐ Emergency Contact ☐ Next of Kin

Insurance Information

Primary Insurance: _____ Subscriber: _____

Address: _____ Subscriber D.O.B.: _____

Subscriber Social Security #: _____ - _____ - _____ ID #: _____ Group #: _____

Patients Relationship to Subscriber: _____

Subscribers Employer, Address, Phone: _____

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE MAY BE CHARGED on all balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

Signature: _____ Date: _____

Respiratory & Sleep Specialists, LLC

PATIENT MEDICAL HISTORY

Todays Date: _____

Patient Last Name: _____ First Name: _____MI: _____

Date of Birth: _____ Name of Primary Care Provider: _____

Name of Referring Provider (If Different From Primary): _____

Please list your health conditions in order of priority along with other practitioners you may be seeing for the condition:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Briefly describe the reason for your visit today: _____

_____

_____

Have you ever been exposed to tuberculosis or had a positive skin TB test? ……☐ Yes ☐ No

Allergies

Please list any medications you might be allergic to & describe the reaction you experienced when taking these medications:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Current Medications

Please list any medication that you are currently taking. please include non-prescription medications and vitamins or supplements. Please include the name of the prescription, dose (strength and number of doses per day) and duration (for how long you have been taking this medication. If more oom is needed please continue on the back of this form:

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Respiratory & Sleep Specialists, LLC

Past Medical History

Do you now or have you ever had any of the following: (*please check)*

☐ High Blood Pressure	☐ High Cholesterol	☐Hypothyroidism	☐ Allergies
☐ Skin Problems	☐ Angina	☐ Heart Problems	☐ Heart Murmur
☐ Pneumonia	☐ Pulmonary Embolism	☐ Asthma	☐ Emphysema / COPD
☐ Stroke	☐ Epilepsy (Seizures)	☐ Sleep Apnea	☐ Kidney Disease
☐ Kidney Stones	☐ Crohn's Disease	☐ Colitis	☐ Anemia
☐ Jaundice	☐ Hepatitis	☐ Stomach / Peptic Ulcer	☐ Joint Issues
☐ Tuberculosis	☐ HIV / Aids	☐ Leukemia	☐ Diabetes

☐ Cancer (type): _____

☐ Other medical conditions: _____

_____

_____

_____

Past Surgical History

Please list any surgical procedures you may have had in the past:

_____

_____

_____

_____

Immunization History

Please list all vaccines received and date / year

VACCINE	DATE / YEAR
Influenza / Flu	
Pneumonia	
Tetanus	
Other:	
Other:	

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Family Health History

Please be sure to include current age or age at death, major illness history, including asthma, emphysema / COPD, diabetes, heart disease, osteoporosis, cancer, allergies, etc…

FAMILY MEMBER	LIVING? (AGE) DECEASED (AGE AT DEATH)	MAJOR ILLNESS OR CHRONIC CONDITION
Mother		
Father		
Siblings		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Environmental And Social History

Home / Appartment: (floor style / length of occupancy) _____

Heat: (central forced air / radiator) _____

Air Conditioning: (central / window units / none) Humidifer: (central / separate units / none)

Basement: (damp / musty / seepage / flooding _____

Pillow: ☐ Feather ☐ Non-feather Comforter: ☐ Feather ☐ Non-feather

Pets: ☐ Dog ☐ Cat ☐ Birds ☐ Other: _____

Occupation: _____

Smoking: Currently ☐ Yes ☐ No Packs per day if yes: _____ Number of years: _____

Past smoking history: ☐ Yes ☐ No If yes, when did you quit: _____

Do you have exposure to secondary smoke: ☐ Yes ☐ No Drug or alcohol use? _____

Hobbies: _____

_____

_____

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Review of Systems

Respiratory: (Please check all that apply)

☐ History of COPD ☐ History of Sleep Apnea ☐ History of Pneumonia If so, Number of times: _____

☐ History of Asthma Age Diagnosed? _____ ☐ Episodes of turning blue

☐Frequency of Albuterol use / rescue inhaler use: _____

☐ Cough (*check all that apply*):

___ Brings up sputum, and if so color: _____ ___ Dry, non-productive ___ Disrupts sleep, worse at night

___ Blood in sputum ___ History of TB (tuberculosis exposure)

☐ Acid reflux symptoms

Triggers of your symptoms: (Please check all that apply)

☐ Seasons: (Circle) Spring Summer Fall Winter Year round ☐ Animals ☐ Working or playing outdoors

☐ Strong odors / perfume ☐ Dust exposure ☐ Temperature changes ☐ Aspirin ingestion ☐ Exercise ☐ Tobacco smoke exposure

☐ Medications used for asthma (circle) ALBUTEROL / XOPENEX / Other: _____Frequency: _____

General / Constitutional: ☐ Weight loss or gain: _____LBS ☐ Fevers ☐ Night sweats ☐Decreased energy

Skin: ☐ Rash ☐ Itching ☐ Dryness ☐ Changes in hair growth or loss ☐ Nail changes

Eyes: ☐ Cataracts ☐ Glaucoma ☐ Loss of vision ☐ Blurred vision ☐ Eye pain

Ears, Nose, Mouth, Throat: ☐Headaches: (location, time of onset, duration, precipitating factors) ☐ Vertigo,

☐ Lightheadedness, injury: _____ ☐ Nose Bleeding ☐ Dental difficulties, Gum bleeding, dentures

☐Difficulty swallowing ☐ Painfull swallowing ☐ Neck stiffness , pain, tenderness, masses in thyroid or other areas

Cardiovascular: ☐Chest pain ☐ Heart palpitations ☐ Left arm pain, numbness ☐ Murmur ☐ Difficulty breathing while lying flat

☐ Lower extremity swelling

Respiratory: ☐ As discussed ☐ Shortness of breath, wheezing, stridor, cough ☐ Respiratory infections, TB or exposure

Gastrointestinal: ☐ Abdominal pain ☐ Heartburn ☐ Nausea ☐ Vomiting ☐Constipation ☐ Diarrhea ☐ Abnormal Stools (clay-colored, tarry, bloody, greasy, foul smelling)

Genito-Urinary: ☐ Increased frequency ☐ Urgency ☐ Blood In urine ☐ Prostate problems ☐ Kidney problems

Musculo – Skeletal: ☐ Pain ☐ Swelling in joints, hands or legs ☐ Redness or heat of muscles or joints ☐ Limitation of motion

☐ Muscular weakness ☐ Muscle cramps

Neurologic / Psychiatric: ☐ Convulsions or seizures ☐ Depression ☐ Anxiety ☐ Hyperactivity ☐ ADHD ☐ Dizziness or passing out

Endocrine: ☐ Thyroid disorder ☐ Heat intolerance ☐ Cold intolerance ☐Excessive thirst / hunger

Blood / Lymphatic: ☐ Swollen lymph nodes or "glands" ☐ Easily bruise ☐ Bloody gums or bleed easily ☐ History of lymphoma
☐ HIV testing (Positive Negative) ☐ Blood transfusion

Respiratory & Sleep Specialists, LLC

APPOINTMENT CANCELLATION POLICY

Todays Date: _____

Our goal at ***Respiratory & Sleep Specialists LLC***, is to provide high quality medical care in a timely manner. In order to do so, we have had to establish an appointment cancellation policy. This policy will enable us to better utilize available appointments for our patients in need of medical care.

A scheduled appointment means that time is reserved only for you. We ask that you call at least **24 hours prior** to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient in need of timely medical care. Failure to give **24** hours notice prior to cancellation may result in a "No-show" appointment fee of $25. This fee cannot be billed to your insurance company and will be your direct responsibility.

To cancel, please call 732-737-7801 to speak to the office staff. Before or after regular business hours, please leave a message with your name, appointment time, reason for canceling and a phone number for us to reach you to reschedule.

Thank you for your understanding in this matter.

_____	_____	_____
Patient Signature	Printed Name	Date

Respiratory & Sleep Specialists, LLC

ELECTRONIC COMMUNICATION POLICY

Todays Date: _____

Email and text messages (SMS): Email &text messages are convenient ways for us to communicate, but they are not secure or private. Email passes through many un-secure public servers while traveling between us. Third parties may intercept our messages. Your messages can be read by or forwarded to others, either intentionally or by mistake. By signing at the bottom of this page, you agree to the following:

I understand that email, text messages, and other electronic communications are not perfectly private nor secure in all circumstances and by signing below, I give my permission to **Respiratory & Sleep Specialists, LLC.** to use email, text messages, or other electronic communication to share my personal health information with me, Or other care providers who are an integral part of my care as determined by myself or my primary care provider.

Communications Preferences:

❑ I would like to communicate electronically with my care team and consent for the practice staff to contact me directly electronically regarding my personal health.

❑ I request that **Respiratory & Sleep Specialists, LLC.** staff **NOT** use email when communicating with me about my Protected Health Information (PHI). I however would like to receive email appointment reminders.

❑ I request that **Respiratory & Sleep Specialist LLC,** staff **NOT** use email to communicate with me in **ANY** form. I do **NOT** want to receive email appointment reminders.

I certify that I have read and understand the preferences have I selected above.

_____	_____	_____
Patient Signature	Printed Name	Date

Respiratory & Sleep Specialists, LLC

INSURANCE POLICIES

Todays Date: _____

Please review each section and only sign those sections that pertain to you or your particular type of insurance. Your signature below each policy infers your acknowledgement of that policy. Thank You

Managed Care Plans: Only to be filled out by patients with Managed Care Plans

In order for your visit and / or testing to be covered by your insurance, you may be required to provide this office with a valid referral issued by your primary care physician. If the referral we have on file for you has expired, or, you do not bring a referral as needed, you will be presented with two (2) options: To reschedule your appointment, or , To pay upfront for all services provided to you today.

_____ _____ _____

Patient Signature Print Name Date

Non-Par Insurances: Only to be filled out by patients with insurance policy's with which we are not on par

I am aware that **Respiratory & Sleep Specialists, LLC.** does not participate with my health insurance. Therefore, payment is expected at the time of service unless prior arrangements have been made.

_____ _____ _____

Patient Signature Print Name Date

Financial Responsibility for Payment: All patients to sign

I am aware that due to any of the reasons listed below, it may me possible that my insurance carrier will deny payment for services rendered to me. In that event, I understand that I will be financially responsible for those charges.

- I do not have my insurance card with me
- I do not have a valid referral for this visit
- This office does not participate with my insurance carrier
- I do not have health insurance, and will pay for my visit today

_____ _____ _____

Patient Signature Print Name Date

Diagnostic Testing: For all patients to sign.

Please be aware that following your office visit the doctor may order bloodwork or other diagnostic testing that may not be deemed "medically necessary" by either Medicare or your insurance carrier. It is possible that your insurance carrier has made its own determination as to what tests they deem to be "medically necessary." Therefore, there may be charges not covered by your carrier. In such an event, these charges will become the responsiblilty of the patient.

_____ _____ _____

Patient Signature Print Name Date

Respiratory & Sleep Specialists, LLC

MEDICARE FORM

Todays Date: _____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization/Assignment of Benefits:

I request that payment of authorized Medicare benefits be made to or on my behalf to **Respiratory & Sleep Specialists, LLC.** for any services furnished to me by one of its providers. I authorize any holder of information about me to the Centers for Medicare / Medicaid Services 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 CMS-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. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____	_____	_____
Patient Signature	Print Name	SSN or Medicare ID
_____	_____	_____
Patient Representitive Signature	Relationship	Date

Medi-Gap/Medicare Supplemental Insurance Lifetime Assignment of Benefits

I, the undersigned, have Medi-gap Insurance coverage and assign directly to **Respiratory & Sleep Specialists, LLC.** all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until evoked by me in writing.

_____	_____	_____
Signature of Beneficiary	Insurance ID Number	Date

Respiratory & Sleep Specialists, LLC

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

Todays Date: _____

Respiratory & Sleep Specialists, LLC. reserves the right to modify the privacy practices as outlined in this notice.

I have been given the opportunity to review the notice of Privacy Practices for Respiratory & Sleep Specialists, LLC. on their website www.getresst.com; and I choose the following election from below:

☐ **Yes**, Please provide me with a copy of the Privacy Practices

☐ **No**, It is not necessary to provide me a copy of the Privacy Practices

You have permission to speak with the people listed below with regard to my medical care:
(This section is for anyone other than physicians with whom we can discuss your medical care)

NAME	PHONE NUMBER	RELATIONSHIP

Messages regarding my medical care may be left at:
(Please check all that apply and provide a corresponding contact)

☐ Home:_____ ☐ Work: _____

☐ Cell Phone: _____ ☐ Voice Mail or Answering Machine

☐ E-Mail: _____ ☐ Other: _____

_____ _____
(Please Print Your Name) (Date of Birth)

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Patient Representative, if patient is unable to sign this form) (Date)