HEALTH HISTORY

Confidential

Patient's Name: ______________________ Today's Date: ____________

Age: ______ Birthdate: ______________ Date of last phyical examination: ____________

What is the reason for visit: ______________________________

CONDITIONS Check (✓) the conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lumps
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pace maker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlett fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

MEDICATIONS List medications you are currently taking.	**ALLERGIES** To medications or substances
Pharmacy Name: Phone:	

REVIEW OF SYSTEMS (CIRCLE ALL THAT APPLY)

GENERAL/CONSTITUTIONAL: CHILLS FEVER NIGHT SWEATS WEIGHT LOSS

SLEEP: DAYTIME FATIGUE EXCESSIVE DAYTIME SLEEPINESS SNORING APNEA

STOPPAGE OF BREATHING RESTLESS LEG SYMPTOMS INSOMNIA

OPHTHALMOLOGIC: GLAUCOMA BLURRED VISION

EAR, NOSE, THROAT: NASAL CONGESTION POST-NASAL DRIP DIFFICULTY SWALLOWING

DRY MOUTH NOSEBLEEDS SINUS PAIN SORE THROAT

ENDOCRINE: EXCESSIVE SWEATING EXCESSIVE THIRST

RESPIRATORY: COUGH PAIN WITH INSPIRATION

SHORTNESS OF BREATH AT REST SHORTNESS OF BREATH WITH EXERTION SPUTUM PRODUCTION

WHEEZING

CARDIOVASCULAR: CHEST PAIN AT REST CHEST PAIN WITH EXERTION

DIFFICULTY LAYING FLAT FLUID ACCUMULATION IN THE LEGS IRREGULAR HEARTBEAT

PALPITATIONS

GASTROINTESTINAL: ABDOMINAL PAIN BLOOD IN STOOL DIFFICULTY SWALLOWING

HEARTBURN NAUSEA VOMITING

GENITOURINARY: BLOOD IN URINE DIFFICULTY URINATING

MUSCULOSKELETAL: BACK PAIN JOINT STIFFNESS MUSCLE ACHES PAINFUL JOINTS

SKIN: RASH

NEUROLOGIC: STROKE BALANCE DIFFICULTY DIFFICULTY SPEAKING

DIZZINESS GAIT ABNORMALITY HEADACHE MEMORY LOSS SEIZURES

PSYCHIATRIC: ANXIETY DEPRESSION

DO YOU SMOKE? YES NO

HAVE YOU HAD THE FLU VACCINE? YES NO IF YES, WHEN? ________________________________

HAVE YOU HAD THE PNEUMONIA VACCINE? YES NO IF YES, WHEN? ______________________

PREVNAR 13 ___________ PNEUMOCOCCAL _______________

All information is strictly confidential

FAMILY HISTORY

Fill in health information about your immediate family.

Relation	Age	State of Health	Age of Death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if your blood relatives had any of the following:

Check	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical dependency	
	Diabetes	
	Heart Disease, Strokes	
	High blood pressure	
	Kidney disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood infusion? ☐ Yes ☐ No

If yes give approximate dates.______________________

PREGNANCY HISTORY

Year of birth	Sex of birth	Complications if any

HEALTH HABITS

Check (✓) which substances you use and describe how much you use.

Check	Substance	How much
	Caffeine	
	Tobacco	
	Street drugs	
	Other	

SERIOUS ILLNESS/INJURIES

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

Check	Exposure
	Stress
	Hazardous substances
	Heavy lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ Sign of Patient, Parent, Guardian or Personal Representative

______________ Date

______________________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________ Relationship to patient

______________________________ Reviewed by

______________ Date

Tampa Pulmonary and Sleep Specialists
4620 N. HABANA AVE., SUITE 101. TAMPA, FL 33614
TELEPHONE (813) 875-9362 FAX (813) 876-7055

PATIENT REGISTRATION FORM

IS TODAY'S VISIT RELATED TO ACCIDENT OR INJURY ? (YES OR NO) ______

IF YES, AUTO OR WORK? ______ DATE OF ACCIDENT/INJURY: ______

RACE: ______ ETHNICITY: ______ DOB: ______ SS#: ______

NAME: ______
FIRST MIDDLE LAST SUFFIX

ADDRESS: ______
STREET CITY STATE ZIP CODE

EMAIL: ______

TELEPHONE #: ( ) ______ ( ) ______ ( ) ______
HOME WORK CELL

EMPLOYER: ______ ADDRESS: ______

REFERRING PHYSICIAN: ______
NAME: ADDRESS:

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: ______ GROUP #: ______

CLAIM ADDRESS: ______

TELEPHONE #: ( ) ______ MEMBER ID #: ______

SUBSCRIBER'S NAME: ______ SUBSCRIBER'S SS #: ______

PATIENT'S RELATIONSHIP TO INSURED: ______ SUBSCRIBER'S DATE OF BIRTH: ______

SECONDARY INSURANCE COMPANY: ______ GROUP #: ______

CLAIMS ADDRESS: ______

TELEPHONE #: ( ) ______ MEMBER ID #: ______

SUBSCRIBER'S NAME: ______ SUBSCRIBER'S SS #: ______

PATIENT'S RELATIONSHIP TO INSURED: ______ SUBSCRIBER'S DATE OF BIRTH: ______

RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY IF OTHER THAN PATIENT: ______
LAST FIRST M.I.

SS #: ______ DOB: ______

ADDRESS: ______

TELEPHONE #: ______ EMPLOYER: ______

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ASSIGNMENT OF BENEFITS FORM

Name of Insured (print): ______________________________

Social Security Number: ______________________________

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made of on my behalf to Rozas, Smith, Chandler, Reina, Subramanian, M.D.S., for any medical services provided to me by that organization.

I authorize the release of any medical or other information necesary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on filed by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print):

____

Relationship to Insured:

____

Signature of Insured or Parent/Guardian:

____

Date:

____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

TAMPA PULMONARY AND SLEEP SPECIALISTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 813-875-9362.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.
To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court

order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system as listed below:

1) BAYCARE
2) LABCORP

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer Elvira Kirksey at 813-875-9362.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   Name: ______________________ Phone Number: ______________________

   Name: ______________________ Phone Number: ______________________

   Name: ______________________ Phone Number: ______________________

   Name: ______________________ Phone Number: ______________________

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

   Name: ______________________ Phone Number: ______________________

   Name: ______________________ Phone Number: ______________________

   Name: ______________________ Phone Number: ______________________

   Name: ______________________ Phone Number: ______________________

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent *if other than your home*. (Confidential Communications).

   ____

   ____

4. Please indicate if you want all correspondance from our office sent in a sealed envelope marked "**CONFIDENTIAL**": Yes: ☐ No: ☐

5. Please print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information *if other than your home phone number*: (   ) __________ Email Address: ______________ @ ______________

6. Can contidential messages (e., appointment reminders) be left on your telephone answering machine or voicemail? Yes: ☐ No: ☐

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

PATIENT NAME: ______________________________ (guardian if under 18 years)

______________________________ ______________________
PATIENT/GUARDIAN SIGNATURE DATE

Tampa Pulmonary and Sleep Specialists	4620 N. Habana Ave., Suite 101, Tampa, FL

Tampa Pulmonary and Sleep Specialists
4620 North Habana Avenue, Suite 101
Tampa, Florida 33614

ACKNOWLEDGEMENT OF RECEIPT OF NOTE OF PRIVACY PRACTICES

"You May Refuse To Sign This Acknowlegement"

I,______________________________________, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____
____
____