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: _____

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

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 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 <u>ONLY IN AN EMERGENCY</u>.

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)

_____

_____

_____

PULMONARY DISEASE QUESTIONNAIRE

Name: _____

Address: _____

Phone: _____ DOB: _____ SSN: _____

Race: _____ Sex: _____ Weight: _____Height:_____

Past Medical History:

Have you ever had or been told you had any of the following (If YES, please check off box)

Childhood Illnesses

☐ Rheumatic Fever ☐ Asthma ☐ Allergies

Adult Illnesses

☐ Glaucoma
☐ High Blood Pressure
☐ Hepatitis/Jaundice
☐ Cirrhosis
☐ Colitis
☐ OSA - Sleep Apnea
☐ DVT/PE (Blood Clots)
☐ Pulmonary Hypertension
☐ Stroke or Paralysis
☐ Interstitial Lung Disease

☐ Heart Failure
☐ Diabetes (sugar)
☐ Arthritis
☐ Cancer
Type _____
Diagnosed Year:_____
Treatment
☐ 1 - Radiation
☐ 2 - Chemotherapy
☐ 3 - Immunotherapy

☐ Anemia (low blood)
☐ Asthma
☐ Tuberculosis (TB)
☐ Pneumonia
☐ Pleurisy (chest pains)
☐ Bronchitis
☐ Emphysema
☐ Heart Disease
☐ Covid

Hospitalizations:

Have you ever been hospitalized?: ☐ Yes ☐ No

If YES, please list hospitalizations from first to last, giving the date and reason.

Please include medical illnesses (heart disease, kidney disease, depression, nervous breakdown, etc.), especially any hospitalizations/surgeries regarding the chest, lungs or heart disorders.

1. Year _____ Reason: _____
2. Year _____ Reason: _____
3. Year _____ Reason: _____
4. Year _____ Reason: _____
5. Year _____ Reason: _____
6. Year _____ Reason: _____
7. Year _____ Reason: _____
8. Year _____ Reason: _____

Surgeries:

Have you had a major surgery?: ☐ Yes ☐ No

If YES, please list hospitalizations from first to last, giving the date and reason.

Please include medical illnesses (heart disease, kidney disease, depression, nervous breakdown, etc.), especially any hospitalizations/surgeries regarding the chest, lungs or heart disorders.

1. Year _____ Reason: _____
2. Year _____ Reason: _____
3. Year _____ Reason: _____
4. Year _____ Reason: _____
5. Year _____ Reason: _____
6. Year _____ Reason: _____
7. Year _____ Reason: _____
8. Year _____ Reason: _____

Transfusions:

Have you ever received a blood transfusion?: ☐ Yes ☐ No

If YES, state the reason for the transfusion: _____

Vaccinations:

If you have had any of the following, check and if possible give the date of the last vaccination or booster:

☐ Influenza (Flu) 20_____ ☐ Pneumococcal (Pneumonia) 20_____

☐ Covid 20_____ ☐ RSV Vaccine 20_____

☐ Other _____

Diagnostic / Images:

CT Chest (CAT scan) Date: _____Location: _____

Chest X-Ray Date: _____Location: _____

Pulmonary Function Tests Date: _____Location: _____

Allergy Testing Date: _____Location: _____

Medications:

Please list below **ALL** medications you now take or have taken in the past 6 months. Please include aspirin, laxatives, nerve pills, birth control, vitamins, sleeping pills, etc.; whether they are prescription drugs or not.

Name (if known)	**Reason Taken**	**How Often** *If daily, how many/day*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Continue on following page

Medications: *Contt'd*

4. _____ _____ _____
5. _____ _____ _____
6. _____ _____ _____
7. _____ _____ _____
8. _____ _____ _____
9. _____ _____ _____
10. _____ _____ _____

Allergies:

Are you allergic to any medication or do you have any other allergies?: ☐ Yes ☐ No

If YES, please list the agent to which you are allergic and state the type of reaction you experienced.

Medication	**Date**	**Reaction**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other	**Date**	**Reaction**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Cough: ☐ Yes ☐ No / **Productive**: ☐ Yes ☐ No / ☐ **Cough Up Blood** ☐ Yes ☐ No

Wheezing: ☐ Yes ☐ No

Shortness of Breath: ☐ Yes ☐ No / **At Rest:** ☐ Yes ☐ No / **With Activity:** ☐ Yes ☐ No

Chest Illness:

1. During the past 3 years have you had chest colds, bronchitis, or pneumonia?
   ☐ No, None ☐ Yes, 2 or 3 bouts ☐ Yes, more than 3 bouts
2. During the past 3 years, have any of these kept you off work or in bed for as long as a week?
   ☐ No ☐ Yes
3. When was your last cold? _____

Tobacco Smoking:

1. Have you ever smoked tobacco / marijuana / vaping? ☐ No ☐ Yes
   If NO, skip down to ALCOHOL
2. Have you ever smoked cigarettes? ☐ No ☐ Yes
3. During your total years of cigarette smoking, what is the average number of packs of cigarettes that you smoked each day? _____
4. How many total years have you smoked?_____
5. Have you stopped smoking? ☐ No ☐ Yes
   If YES, how long has it been since you stopped smoking?
   a. _____ months b. _____ years
6. Have you ever smoked cigars regularly? ☐ No ☐ Yes
   a. How many years?_____ b. How many cigars per day? _____
   c. Do you still smoke cigars?_____ d. Do you or did you inhale? _____
7. Have you had a Lung Cancer Screening CT Scan? ☐ No ☐ Yes
   If YES, Date:_____ Location: _____

Alcohol:

Have you ever used alcoholic beverages? ☐ No ☐ Yes

If YES, check below:

☐ None for _____ years ☐ Daily
☐ Presently ☐ To excess on occasion
☐ Social only

Hobby and Leisure History:

Do you have contact with animals in your home? ☐ No ☐ Yes

☐ Birds ☐ Dogs ☐ Cats
☐ Others_____

Do you have hobbies in which you may inhale fumes or dust? ☐ No ☐ Yes

If YES, please give details: _____

Occupation History:

Please list below all previous occupations from year first job to your current job:

_____ _____
_____ _____
_____ _____

Environmental Exposure History:

Please mark any of the following occupations that you have worked at and indicate the length of time you worked there:

☐ Asbestos . . . . . (Months / Years) _____/_____

☐ In a foundry . . . . . (Months / Years) _____/_____

☐ In a coal mine . . . . . (Months / Years) _____/_____

☐ In any other mine . . . . . (Months / Years) _____/_____

State _____ Type _____

☐ In a quarry . . . . . (Months / Years) _____/_____

☐ In a pottery . . . . . (Months / Years) _____/_____

☐ In a cotton, flax, or hemp mill . . . . . (Months / Years) _____/_____

☐ In asbestos, milling, processing, painting, spraying . . . . . (Months / Years) _____/_____

☐ As a tunnel worker . . . . . (Months / Years) _____

☐ As a sandblaster . . . . . (Months / Years) _____/_____

☐ As a rock cutter . . . . . (Months / Years) _____/_____

☐ In manufacturing beryllium . . . . . (Months / Years) _____/_____

☐ In manufacturing ceramics, glass or abrasives . . . . . (Months / Years) _____/_____

☐ In any other job with exposure to dust, gas or fumes . . . . . (Months / Years) _____/_____

Describe the job: _____

_____

Family History:

Father:

Please check and describe where appropriate:

☐ Living Age:_____ Illness _____

☐ Deceased Age at death: _____ Cause _____

Mother:

☐ Living Age:_____ Illness _____

☐ Deceased Age at death: _____ Cause _____

Brothers and Sisters:

☐ Living Age:_____ Illness _____

☐ Deceased Age at death: _____ Cause _____

☐ Living Age:_____ Illness _____

☐ Deceased Age at death: _____ Cause _____

☐ Living Age:_____ Illness _____

☐ Deceased Age at death: _____ Cause _____

☐ Living Age:_____ Illness _____

☐ Deceased Age at death: _____ Cause _____

NAME: _____

DATE:_____

SLEEP

DAYTIME FATIGUE EXCESSIVE DAYTIME SLEEPINESS STOPPAGE OF BREATHING SNORING

BEING TOLD IRREGULAR BREATHING DURING SLEEP RESTLESS LEGS SYMPTOMS INSOMNIA

GENERAL/CONSTITUTIONAL

CHILLS FEVER NIGHTTIME SWEATS WEIGHT LOSS

EYES

GLAUCOMA BLURRED VISION DIMINISHED VISION DISCHARGE PAIN

EARS, NOSE, THROAT

NASAL CONGESTION POST NASAL DRIP SNEEZING PERSISTENT HOARSENESS DECREASED HEARING DIFFICULTY SWALLOWING

DRY MOUTH EAR PAIN NOSEBLEEDS RINGING IN EARS SINUS PAIN SORE THROAT

ENDOCRINE

COLD INTOLERANCE EXCESSIVE SWEATING EXCESSIVE THIRST

RESPIRATORY

COUGH PAIN WITH INSPIRATION SHORTNESS OF BREATH AT REST SHORTNESS OF BREATH WITH EXERCISE

SPUTUM PRODUCTION WHEEZING

CARDIOVASCULAR

CHEST PAIN AT REST CHEST PAIN WITH EXERCISE DIFFICULTY LYING FLAT FLUID ACCUMULATION IN LEGS

IRREGULAR HEARTBEAT SHORTNESS OF BREATH WHEN LYING FLAT PALPITATIONS

GASTROINTESTINAL

ABDOMINAL PAIN BLOOD IN STOOL CONSTIPATION DIARRHEA DIFFICULTY SWALLOWING HEARTBURN

NAUSEA VOMITING

GENITOURINARY

BLOOD IN URINE DIFFICULTY URINATING FREQUENT URINATION PAIN/DISCOMFORT WHEN URINATING

URINE INCONTINENCE

MUSCULOSKELETAL

GOUT BACK PAIN JOINT STIFFNESS MUSCLE ACHES PAINFUL JOINTS

NAME: _____

DATE:_____

SKIN

DISCOLORATION ECZEMA ITCHING RASH SKIN CANCER

NEUROLOGIC

MIGRAINE HEADACHES STROKE BALANCE DIFFICULTY DIFFICULTY SPEAKING DIZZINES DIFFICULTY WITH YOUR GAIT
HEADACHES MEMORY LOSS SEIZURES/EPILEPSY TINGLING/NUMBNESS TREMOR

PSYCHIATRIC

ANXIETY DEPRESSED MOOD DIFFICULTY SLEEPING

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?

HAVE YOU HAD THE COVID-19 VACCINE? YES NO IF YES, WHEN?

HAVE YOU TESTED POSITIVE FOR COVID-19? YES NO IF YES, WHEN?