PATIENT INFORMATION

First & Last Name:_____ **Date of Birth:**____/_____/_____

Address: _____ **Apt Number:** _____

City: _____**State:** _____ **Zip Code:** _____ **Male**_____ **Female**_____

Primary Phone Number: (_____)_____-_____ **Alternate Number:** (_____)_____-_____

Referring Physician: _____ **Primary Care Doctor:**_____

Marital Status? Single Married Widowed Divorced Other:_____

Occupation (Current & Former): _____ **Email Address:** _____

Local Pharmacy Name & Cross Streets and/or Mail-In Pharmacy Name: _____

Oxygen /DME Company (if applicable): _____

Emergency Contact_____**ph#**_____**Relation**_____

PRIMARY Insurance:

Insurance Company Name: _____

Insured Name: Self or Other (name): _____ **Insured Date of Birth:**_____/_____/_____

Policy ID #: _____ **Group Number:** _____

SECONDARY Insurance:

Insurance Company Name: _____

Insured Name: Self or Other (name): _____ **Insured Date of Birth**:_____/_____/_____

Policy ID #: _____ **Group Number:** _____

Medication List

Name:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medication?

Medication Name **& Reaction**

_____

_____

_____

_____

_____

SOCIAL HISTORY

Who do you live with? Alone Spouse Children: How many? _____ Other:_____

Place of birth: _____ **Years you've lived in Arizona?** _____

Any pets? Yes No if yes, What kind? _____ How many?_____

Are you a: current smoker former smoker nonsmoker **If former smoker:** Quit date? _____

If "current smoker": # of cigarettes you smoke a day? _____ Are you interested in quitting? Yes No Maybe

Hospitalizations & Surgeries

Please list major illnesses and operations with approximate year

_____ _____

_____ _____

_____ _____

_____ _____

Family Medical History: (alive/dead, diabetes, heart disease, lung Disease, any cancer etc…)

Father: _____

Mother: _____

Sister/Brothers _____

Children: _____

Date of Flu Shot: ____/____/_____ Date of Pneumonia Shot: ____/____/_____

Illnesses and Symptoms

Check the ❑ if you have / have had the following:

Eye Disease ❑
Ear Disease ❑
Nose / Sinus Disease ❑
Mouth / Throat Disease ❑
Seizure Disorder / Convulsions ❑
Frequent Severe Headache ❑
Paralysis ❑
Loss of Sensation ❑
Thyroid Disease ❑
Skin Disease ❑
Night Sweats ❑
Weight Loss (Recent) ❑
Weight Gain (Recent) ❑
Chest Pain ❑
Palpitations / Fluttering Heart ❑
Swelling Feet, Ankles ❑
Heart Attack ❑
Kidney Disease / Stones ❑
Bladder Disease ❑
Blood in Urine ❑
Urinary Difficulty ❑
Prostate Trouble ❑

Heartburn ❑
Ulcer ❑
Other Stomach Trouble ❑
Liver Disease / Hepatitis ❑
Bowel Disease / Colitis ❑
Change in Bowel Habits ❑
Rectal Bleeding ❑
Black, Tarry Stools ❑
Arthritis ❑
Anemia ❑
Sexually Transmitted Disease ❑
Diabetes ❑
Psychiatric or Emotional Illness ❑
Alcohol Use ❑
IV Drug Use ❑
Frequent Aspirin, Tylenol, etc. ❑

List pets, animals, or birds at home:

_____

_____

_____

ARIZONA RESPIRATORY MEDICINE, PC

Dr. A. Kadikar, MD FCCP
290 S. Alma School Rd. Suite 11
Chandler, AZ 85224
Office: (480) 759-1027
Fax: (480) 759-1031

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

DATE: _____

PATIENT: _____

DOB: _____

I, _____, authorize the release of the below specified records to Arizona Respiratory Medicine, PC and I understand that the following information will be used in accordance with my medical care:

_____

_____

_____

_____

I, understand that the above information is important to my continuing care and may be disclosed to my referring physician, insurance companies, employers and third party payors as necessary.

_____ _____

Patient or Patient's Representative Date

_____

Print Name of Patient's Representative and Relationship

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ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Arizona Respiratory Medicine, PC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

DATE: _____ _____

Signature of Patient or Patient's Representative

_____

Print Name of Patient or Patient's Representative

FOR OFFICIAL USE ONLY

I, _____ , made a good faith effort to obtain written acknowledgment of _____'s receipt of the Notice of Privacy Practices of Arizona Respiratory Medicine, PC. However, I could not obtain written acknowledgement because: (please check the appropriate reason below)

◯ Individual refused to sign this Acknowledgement

◯ Communications barrier prohibited obtaining written acknowledgement

◯ An emergency situation prevented obtaining written acknowledgement

◯ Other (please specify)

_____

_____

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FINANCIAL AGREEMENT

BY PLACING MY SIGNATURE ON THIS PAGE, I AGREE TO THE FOLLOWING:

- **I am consenting to treatment and services.**
- **I understand I am financially liable for all services performed whether or not paid by insurance.**
- **I authorize my insurance company to make payments directly to Anita Kadikar, MD FCCP.**
- **I authorize my health care provider to release all information necessary to secure payment of benefits.**
- **I understand I am responsible for confirming and understanding my insurance company's coverage limitations and policies, including my obligation for deductibles, co-insurance and co-payments.**
- **I understand all payments are due at the time of service, including co-pays, deductibles, co-insurance, and balances.**
- **I understand that if I do not have insurance coverage, the full payment for services is due at the time services are rendered, unless payment arrangements are made (payment plan).**
- **I understand it is my responsibility to inform the billing department of any changes in insurance coverage immediately**
- **I understand I am responsible for charges if correct insurance is not provided and billed timely.**
- **I agree to pay all cost of collection, and reasonable attorney's fees.**
- **I understand and agree to pay the $25 fee for all returned checks**

_____ _____

Patient / Legal Representative's Signature Date

_____

Print Name

**** IF YOUR INSURANCE HAS CHANGED SINCE YOUR LAST VISIT, WE NEED A COPY OF YOUR NEW INSURANCE CARD, THANK YOU!!! ****

Name:_____

GENERAL/CONSTITUTIONAL

Change in appetite	◯ **Admits**	◯ **Denies**
Chills	◯ **Admits**	◯ **Denies**
Fever	◯ **Admits**	◯ **Denies**
Headache	◯ **Admits**	◯ **Denies**
Lightheadedness	◯ **Admits**	◯ **Denies**
Night Sweats	◯ **Admits**	◯ **Denies**

ALLERGY/IMMUNOLOGY

Congestion	◯ **Admits**	◯ **Denies**
Rash	◯ **Admits**	◯ **Denies**
Sneezing	◯ **Admits**	◯ **Denies**
Watery eyes	◯ **Admits**	◯ **Denies**

ENT

Difficulty swallowing	◯ **Admits**	◯ **Denies**
Sore throat	◯ **Admits**	◯ **Denies**
Sinus pain	◯ **Admits**	◯ **Denies**
Nosebleed	◯ **Admits**	◯ **Denies**

RESPIRATORY

Chest pain	◯ **Admits**	◯ **Denies**
Cough	◯ **Admits**	◯ **Denies**
Coughing up blood	◯ **Admits**	◯ **Denies**
Sputum (mucus) production	◯ **Admits**	◯ **Denies**
Wheezing	◯ **Admits**	◯ **Denies**
Short of breath w/ exertion	◯ **Admits**	◯ **Denies**

Name:_____

CARDIOVASCULAR

Chest pain at rest	◯ **Admits**	◯ **Denies**
Dizziness	◯ **Admits**	◯ **Denies**
Palpitations	◯ **Admits**	◯ **Denies**

GASTROINTESTINAL

Constipation	◯ **Admits**	◯ **Denies**
Decreased appetite	◯ **Admits**	◯ **Denies**
Diarrhea	◯ **Admits**	◯ **Denies**
Nausea	◯ **Admits**	◯ **Denies**
Vomiting	◯ **Admits**	◯ **Denies**
Heartburn	◯ **Admits**	◯ **Denies**

GENITOURINARY

Blood in urine	◯ **Admits**	◯ **Denies**
Difficulty urinating	◯ **Admits**	◯ **Denies**

MUSKULOSKELETAL

Painful joints	◯ **Admits**	◯ **Denies**
Swollen joints	◯ **Admits**	◯ **Denies**
Weakness	◯ **Admits**	◯ **Denies**
Muscle aches	◯ **Admits**	◯ **Denies**

SKIN

Hives	◯ **Admits**	◯ **Denies**
Rash	◯ **Admits**	◯ **Denies**
Eczema	◯ **Admits**	◯ **Denies**

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Arizona Respiratory Medicine PC is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you come to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other healthcare provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:
Any person or person you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process healthcare claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities who need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS:
You have the right to inspect your Protected Health Information. You also have the right to amend any errors you find in your record.
If you leave this practice, your Protected Health Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS:
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Service at 200 Independence Avenue, S.W. Room 509F, HHH Building Washington D.C. 20201. You may also contact the Privacy Officer of this Practice at 480-759-1027.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This Notice is effective as of April 13, 2016.