Tampa Bay Pulmonary Associates, P.A.

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REGISTRATION FORM

PATIENT INFORMATION/INFORMACION DEL PACIENTE				
Today's Date/Fecha de Hoy:	Primary Dorctor/Doctor Primario:			
Last Name/Apellido:	First Name/Nombre:	DOB/Fecha de Nacimiento:		
Address: Dirección:				
Social Security no.: # Seguro Social:	Home phone no.: Número de teléfono:	Cell phone no.: # Célular:		
Email: Correo electrónico:	Pharmacy and phone no. Farmacia y # telefónico:	Marital Status: Estado Civil:		
Who referred you to us: (Quién lo refirió a nosotros) __ Primary Care Physician/Doctor Primario __ Flyer/Volantes __ Specialist/Especialista __ Friend/Amigo/a __ Website/Sitio Web __ Self/Usted Other/Otro:_____				
IN CASE OF EMERGENCY EN CASO DE EMERGENCIA				
Name of relative or friend : Nombre de algún familiar o amigo:	Relationship to patient: (Relación al paciente)	Home phone no.: **(Numero de teléfono)**	Work phone no.: **(Numero de teléfono del trabajo)**	
INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)** Información del seguro (FAVOR DE ENTREGAR TARJETAS DE SEGURO A LA RECEPCIONISTA)				
Please indicate primary insurance: (Por favor indique seguro primario)				
Subscriber's name: (Nombre del Asegurado)	Policy / Member ID # (# de póliza)	Group no.: (# de Grupo)	Effective Date (Effectivo desde)	Co-payment: (Co-pago)
Patient's relationship to subscriber: (Relación al paciente)				
Name of secondary insurance (if applicable): (Seguro secundario)	Policy # (# de póliza)	Group no.: (# de Grupo)		
Patient's relationship to subscriber: (Relación al paciente)				
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Microsoft Corporation or insurance company to release any information required to process my claims. (La información anterior es verdadera a mi mejor conocimiento. Autorizo a mis beneficios de seguro a pagar directamente al medico. Entiendo que soy financieramente responsable por cualquier saldo. También autorizo a Microsoft Corporation o compañía de seguros para liberar toda la información necesaria para procesar mis reclamos.)				
_____ Patient /Guardian Signature Date				

HEALTH HISTORY QUESTIONNAIRE

(HISTORIA DE SALUD)

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.
Todas las preguntas contenidas en este cuestionario son estrictamente confidenciales.
y pasarán a formar parte de su expediente médico.

PERSONAL HEALTH HISTORY (HISTORIA PERSONAL DE SALUD)

Immunizations (Vacunas)	☐ **Influenza (FLU Shot)** Last date given: ___/___/_____	☐ **Pneumonia Shot** Last date given: ___/___/_____

Check all medical problems that other doctors have diagnosed: (Revise todos los problemas médicos que otros médicos han diagnosticado:)

☐ Lung Disease (Enfermedad de Pulmón)	☐ Sarcoidosis (Sarcoidosis)	☐ Diabetes (Diabetes)
☐ Asthma (Asma)	☐ Insomnia (Insomnio)	☐ HIV (HIV)
☐ COPD (COPD)	☐ Restless Leg (Piernas Inquietas)	☐ Hepatitis (Hepatitis)
☐ Emphysema (Enfisema)	☐ Recurrent Sinusitis (Sinusitis Recurrente)	☐ Lupus (Lupus)
☐ Chronic Bronchitis (Bronquitis Crónica)	☐ Lung Cancer (Cancer del Pulm*ón)*	☐ Other type of cancer: Otro tipo de cancer:
☐ Tuberculosis Tuberculosis)	☐ Rheumatoid Arthritis (Artritis Reumatoide)	Explain_____ Expplique _____

☐ Fibromyalgia (Fibromialgia)	☐ DVT/Blood Clot (Coágulo de Sangre)	**Recent Changes in: Cambios recientes de:** ☐ Weight (Peso)
☐ Heart Disease (Enfermedad de Corazón)	☐ Pulmonary Emboli (Embolia Pulmonar)	☐ Energy level (Energia)
☐ Hypertension (Alta Presión)	☐ Kidney Disease (Enfermedad de Riñones)	☐ Ability to sleep (Capacidad para dormir)
☐ Angioplasty/Stents (Angioplastia)	☐ High Cholesterol (Colesterol Alto)	☐ Other pain/discomfort: (Otra molestia/ Dolor)
☐ Heart Failure (Insuficiencia Cardiaca)	☐ Thyroid Disease Enfermedad de Tiroide)	Explain: Explique:_____

Other major Illnesses: (Alguna otra enfermedad):

_____

Surgeries (Cirugías)

Year (Año)	Reason (Razón)	Hospital

Other hospitalizations in the last 2 years (Hospitalizaciones en los últimos 2 años)

Year (Año)	Reason (Razón)	Hospital

Allergies to medications: (Alergias a medicamentos)

Check all that apply: (Marque todo lo que corresponda:)

Penicillin/Penicilina Codeine /Codeina Sulfa/Sulfa Morphine/Morfine Aspirin/Aspirina IV Contrast Dye/Contraste Latex Iodine/Yodo INSAID

Other: (Otro:) _____

Reactions you have had: Rash Hives Itching Swelling Others: _____

Reacciones que han tenido: Salpullido Urticaria Comezón Hinchazón Otros: _____

Medications
(Medicamentos)

Name of Medications (Nombre del Medicamento)	Strengths (Dosis)	Frequency Taken (Cuantas veces al dia)

HEALTH HABITS AND PERSONAL SAFETY (HÁBITOS DE SALUD Y SEGURIDAD PERSONAL)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.
TODAS LAS PREGUNTAS CONTENIDAS EN ESTE CUESTIONARIO SON OPCIONALES Y SE MANTENDRÁ ESTRICTAMENTE CONFIDENCIAL.

Exercise

Ejercicio

- ☐ Sedentary (No exercise) Sedentarismo (Ningún ejercicio)
- ☐ Mild exercise (climb stairs, walk for 3 blocks, golf) El ejercicio suave (subir escaleras, caminar 3 cuadras, golf)
- ☐ Occasional vigorous exercise (work or recreation, less than 4x/week for 30 minutes) El ejercicio vigoroso ocasional (trabajo o recreación, a menos de 4x / semana durante 30 minutos)
- ☐ Regular vigorous exercise (work or recreation 4x/week for 30 minutes) Regular el ejercicio vigoroso (trabajo o recreación 4x / semana durante 30 minutos)

Caffeine

☐ None ninguno ☐ Coffee Café ☐ Tea Té ☐ Cola Soda

How many cups or cans per day? Cuantas tazas/latas al dia?

Alcohol

Do you drink alcohol? Toma alcohol? ☐ Yes/Si ☐ No/No

If YES: How many drinks per year? Cuantos bebidas al año?

☐ Monthly or less Mensualmente ☐ 2 to 4 times a month 2 a 4 veces por mes ☐ 2 to 3 times a week 2 a 3 veces a la semana ☐ 4 or more times a week 4 o más veces a la semana

* How drinks did you have on a typical day? Cuantos tragos en un dia típico? ☐ 1 to 2 drinks 1 a 2 tragos ☐ 3 to 4 drinks 3 a 4 tragos ☐ 5 to 6 drinks 5 a 6 tragos ☐ 7 to 9 drinks 7 a 9 tragos ☐ 10 or more drinks 10 o más

* How often did you have 6 or more drinks on one occasion in the past year? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily
¿Con qué frecuencia usted tiene 6 o más bebidas en una ocasión en el último año? • Nunca • Menos mensual • Mensual • Semanal • Diaria

Tobacco

Do you currently smoke? Fuma? ☐ YES/SI ☐ NO/NO ☐ NEVER (nonsmoker)/ NUNCA

If YES, which type and how many a day:
Que tipo y cuantos al día?
☐ **Cigarettes/Cigarillos**
How many cigs a day:_____
_____

☐ **Chew/Masticado** # a day _____

☐ **Pipe/Pipa** # a day _____

☐ **Cigars/Cigaros** # a day _____

Former smoker: **How long ago did you quit?** ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-5 yrs ☐ 5-10 yrs ☐ 10 or more yrs

Personal Safety

Do you live alone? Vive solo (a) ?	☐ Yes/Si	☐ No
Do you have frequent falls? Tiene caidas frequentes?	☐ Yes/Si	☐ No
Do you have vision or hearing loss? Ha tenido perdida de audición/vision?	☐ Yes/Si	☐ No
Do you have an Advance Directive or Living Will? ¿Tiene una directiva anticipada o testamento vital?	☐ Yes/Si	☐ No
Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? El abuso físico y / o mental también se ha convertido en los principales problemas de salud pública en este país. Esto a menudo toma la forma de comportamiento verbal que amenaza o abuso físico o sexual real. ¿Le gustaría discutir este tema con su proveedor?	☐ Yes/Si	☐ No

<u>Durable Medical Equipment</u> (DME):

Check which equipment you use: (Indique que equipo usa:)

☐ Oxygen/Oxígeno ☐ Nebulizer/Nebulizador ☐ CPAP/ BiPAP

Name of company where you received the equipment: (**Nombre de la Compañia que le proveyó el equipo**:) _____

FAMILY HEALTH HISTORY (HISTORIAL MEDICO FAMILIAR)					
	ALIVE/DEATH (VIVO/MUERTO)	SIGNIFICANT HEALTH PROBLEMS (**PROBLEMAS DE SALUD**)		ALIVE/DEATH (VIVO/MUERTO)	SIGNIFICANT HEALTH PROBLEMS **(PROBLEMAS DE SALUD)**
Father (Padre)			**Children** (HIJOS)	☐ M ☐ F	
Mother (Madre)				☐ M ☐ F	
Siblings Hermanos (a) Brother and Sister	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal (ABUELA MATERNA)*		
	☐ M ☐ F		**Grandfather** *Maternal ABUELO MATERNO*		
	☐ M ☐ F		**Grandmother** *Paternal ABUELA PATERNA*		
	☐ M ☐ F		**Grandfather** *Paternal ABUELO PATERNO*		

OTHER PROBLEMS (OTROS PROBLEMAS)

Check if you have, or have had any symptoms in the following areas to a significant degree:
(Compruebe si usted tiene o ha tenido algún síntoma en las siguientes áreas de un grado significativo:)

☐ Skin (Piel)	☐ Chest/Heart (Pecho/Corazón)
☐ Head/Neck (Cabeza/Cuello)	☐ Back (Espalda)
☐ Ears (Oidos)	☐ Intestinal (Intestinal)
☐ Nose (Nariz)	☐ Bladder (Vejiga)
☐ Throat (Garganta)	☐ Bowel (Intestino)

Tampa Bay Sleep Center

SLEEP DISORDERS SCREENING FORM
Evaluación para el desorden de sueño

DATE/FECHA: _____
PATIENT NAME/ NOMBRE: _____
BIRTHDATE/ FECHA DE NACIMIENTO: _____
PLEASE DESCRIBE YOUR SLEEP PROBLEM/ FAVOR DE EXPLICAR SU PROBLEMA:

_____
_____
_____

HOW LONG HAVE YOU HAD THIS PROBLEM WITH YOUR SLEEP? / HACE CUANTO TIENE ESTE PROBLEMA CON EL SUEÑO?

_____

PLEASE CHECK YES OR NO/Favor de seleccionar SI o NO

1. DO YOU SNORE? / USTED RONCA? ____YES/SI ____NO
2. DO YOU GASP OR CHOKE IN YOUR SLEEP? / SE ASFICCIA O SE AHOGA DURMIENDO? ____YES/SI ____NO
3. HAS ANYONE EVER TOLD YOU THAT YOU STOP BREATHING OR BREATH IRREGULARLY WHEN YOU SLEEP? / LE HA DICHO ALGUIEN QUE PARA DE RESPIRAR IREGULARMENTE MIENTRAS DUERME? ____YES /SI ___NO
4. DO YOU WAKE UP TIRED, EVEN THOUGH YOU SLEPT AT NIGHT? / SE DESPIERTA CANSADO AUNQUE PIENSE QUE DURMIO TODA LA NOCHE? ____YES/SI ____NO
5. DO YOU HAVE TROUBLE FALLING ASLEEP? / TIENE PROBLEMAS PARA QUEDARSE DORMIDO? ____YES/SI ____NO
6. DO YOU HAVE TROUBLE STAYING ASLEEP? / TIENE PROBLEMAS PARA MANTENERSE DORMIDO? ____YES/SI ____NO
7. DO YOU HAVE TO GET UP TO GO TO THE BATHROOM AT NIGHT? / TIENE QUE LEVANTARSE PARA IR AL BAÑO? ____YES/SI ____NO
8. DO YOU GET IRRITATED OR FORGETFUL?/ IRRITADO U OLVIDADIZO____YES/SI ____NO
9. DO YOU HAVE INSOMNIA? / TIENE INSOMNIO? ____YES/SI ____NO
10. DO YOUR LEGS AND/OR ARMS TWITCH OR ACHE AT NIGHT? / TIENE MOVIMIENTOS DE BRAZOS/PIERNAS INVOLUNTARIOS? ____YES/SI ____NO
11. DO YOU HAVE VIVID DREAMS? / TIENE SUEÑOS VIVIDOS? ____YES/SI ____NO
12. DO YOU WALK OR TALK IN YOUR SLEEP? / CAMINA O HABLA DORMIDO? ____YES/SI ____NO
13. DO YOU EVER ACT OUT YOUR DREAMS? / ACTUA SUS SUEÑOS? ____YES/SI ____NO
14. HAVE YOU EVER HAD EAR, NOSE OR THROAT SURGERY? / HA TENIDO OPERACION DE OIDOS, NARIZ O GARGANTA? ____YES/SI ____NO
15. HAVE YOU EVER HAD A SLEEP STUDY? / HA TENIDO ALGUN ESTUDIO DE SUEÑO ANTERIORMENTE? ____YES/SI ____NO
16. WHERE AND WHEN WAS THIS STUDY? / CUANDO Y DONDE FUE EL ESTUDIO? _____
17. WHAT IS YOUR NECK CIRCUMFERENCE? / CUÁL ES LA MEDIDA DE SU CUELLO? _____

EPWORTH SLEEPINESS SCALE

Choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate. / Utilice la siguiente escala para elegir el número más apropiado para cada situación:

0 = would never doze or sleep/No quedaría dormido 2 = moderate chance of dozing or sleeping/Probabilidad moderada de quedar dormido 1 = slight chance of dozing or sleeping/Poca probabilidad de quedar dormido 3 = high chance of dozing or sleeping/Alta probabilidad de quedar

Situation/Situación	dormido ***Chance of Dozing or Sleeping*** **Probabilidad de quedar dormido/a**
Sitting and reading/ Sentado y leyendo	
Watching TV/ Viendo Televisión	
Sitting inactive in a public place/ Sentado inactivo en un lugar público	
Being a passenger in a motor vehicle for an hour or more/ Siendo pasajero de un vehículo por mas de 1 hora	
Lying down in the afternoon / Acostado en la tarde	
Sitting and talking to someone / Sentado y hablando con alguien	
Sitting quietly after lunch (no alcohol)/ Sentado callado despues del almuerzo (sin alcohol)	
Stopped for a few minutes in traffic/ Parado por unos minutos en el tráfico	

Total :	Score:	0-10 normal	10-12 Borderline	12-24 Abnormal

Authorization for Release of Medical Records:
Consentimiento para obtener Archivos Médicos:

Name_____ Date of Birth_____

Last 4 digits of social security number_____

I authorize and request Tampa Bay Pulmonary & Associates, P.A., to receive copies of medical records from any physician's office, laboratory, and hospital that has any health information on me. The information that is being requested is needed as soon as possible in order to get the proper medical treatment I need at the time the services are rendered.

Dr's Name: _____ Telephone #: _____

Address_____ Fax #:_____

_____

Medical Information Requested:

☐ All Records

☐ Specific Records from _____ to _____

☐ Other _____

This information will be used to further assist in my medical care, and should be

Faxed to: (813) 933-8784

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Printed name of Patient Representative

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have to right to revoke this consent at any time unless the facility, which is to make to disclosure of information, has already done so in reliance on the consent

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Office Policy:
Póliza de la oficina:

Cancellation - Patient no shows create gasp in the physician schedules that could be otherwise used to accommodate patient with urgent problems. Therefore we require a 24 hours notice of cancellation for are not notified we will charge **$25** for a missed appointment and **$100** for a missed sleep study.

Forms -The completion of forms in addition to the usual and customary insurance claim forms or prescription authorization forms represents an administrative service above and beyond the provision of medical care. The volume of these requests has increased tremendously resulting in the need for additional staff costs. **Patient must set-up and appointment for completion of paper work.** This includes but is not limited to FMLA forms, private disability or cancer policy forms, school or work disability or limitation forms.

Records Request - Patients are entitled to copy of their own office visit encounters and they will be furnished upon request. However, prior to your request we will need at least **2 weeks in advance** to have all records requested ready.

Assignment of Benefits - I hereby authorize my insurance benefits to be paid directly to Tampa Bay Pulmonary & Associates, P.A. I understand that I am responsible for non-covered services and I authorize the release of medical information to my insurance company.

Co-pays - Co-pays and deductibles are due at the time of services. We will make every effort to make an accurate determination of patient responsibility based on your insurance plan and use of the online insurance verification service Availity.

Referrals - If you have a HMO requiring a referral or prior authorization from your Primary Care Physician. **Please understand that this is the insurance plan you selected and you are responsible for obtaining the referral prior to the office visit**. Failure to do so will result in inconvenience to you and the Physician and your appointment being rescheduled.

Lifetime - I authorize the release of medical information to my insurance company to process claims. I authorize this to be used as a lifetime signature to avoid the inconvenience of having to sign individual insurance claim forms at every office visit.

_____ _____

Signature/ Firma Date

Notice of Privacy for Patient's Protected Health Information
Aviso de Privacidad de la Información de Salud Protegida del Paciente

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office uses and discloses your protected health information for the following reasons:
To share with other treating health care providers regarding your health care.
To submit to insurance companies claims or other payers to verify that treatment has been rendered.
To verify patient's benefits in a health care insurance plan.
Release of information required by State or Federal Public Health Law.
To assist in overcoming a language barrier when caring for a patient.
Business associates providing written assurances that your privacy has been attained.
Situations deemed emergent or medically urgent by the Physicians.
Abuse, neglect, or domestic violence in accordance with State and Federal Law.
Appointment reminders to household members or on answering machines.
Sign-in logs may be disclosed to verify office visits.
Occasional photographs and other letters and cards of appreciation from patients that are displayed.

Any other disclosures will only be made with your specific written prior authorization.

You have right to:
Revoke authorization in writing at any time by specifying who you want restricted.
Speak to our privacy officer who can be reached at 813-935-5501.
Inspect copy and amend your protected health information as allowed by law.
To render a complaint to our privacy office or to the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received this notice with full understanding.

Name of Patient_____

Signature_____

Date_____