TODAY'S DATE:- _____

PULMONARY MEDICAL CONSULTANTS
MUSTAFA NAEEM M.D.

PATIENT INFORMATON:

LAST NAME:_____ **FIRST:**_____ **MI**_____
ADDRESS:_____ **APT#**_____
CITY:_____ **STATE:**_____ **ZIP:**_____ **COUNTY**_____
HOME PHONE:_____ **CELL:**_____
EMAIL ADDRESS: _____
DATE OF BIRTH:_____ **SOCIAL SECURITY NUMBER:**_____
PLEASE CIRCLE ONE: SEX: M / F MARITAL STATUS: M / S RACE:_____
PLEASE CIRCLE ONE: EMPLOYED RETIRED DISABLED
EMPLOYER NAME:_____ **PHONE #:**_____

GUARANTOR INFORMATION:

LAST NAME:_____ **FIRST:**_____ **MI:**_____
ADDRESS:_____ **APT#**_____
CITY:_____ **STATE:**_____ **ZIP:**_____
HOME PHONE:_____ **CELL:**_____

EMERGENCY CONTACT INFORMATION:

LAST NAME:_____ **FIRST:**_____ **MI:**_____
HOME PHONE:_____ **CELL:**_____
WORK NUMBER:_____ **EXT:**_____

PATIENT NAME: _____

DOB: _____ **DATE:** _____ **ACCT#** _____

INSURANCE INFORMATI0N: **PATIENT WILL BE SELF PAY:** ☐

PRIMARY INS: _____ **ID#:** _____

GROUP #: _____ **PHONE#:** _____

SECONDARY INS: _____ **ID#:** _____

GROUP#: _____ **PHONE#:** _____

*** IF PATIENT IS COVERED BY GUARANTORS INSURANCE ***

PLEASE PROVIDE THE FOLLOWING GUARTORS INFORMATION

RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

PRIMARY CARE DOCTOR: _____

PHONE: _____ **FAX:** _____

NAME OF PHARMACY: _____

PHONE: _____ **FAX:** _____

PATIENT NAME:_____

DOB:_____ DATE:_____ ACCT# _____

MEDICAL HISTORY: Please check any symptoms you are currently having or have had in the past year.

GENERAL:
- ☐ Blurred vision
- ☐ Chills
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of appetite
- ☐ Night sweats
- ☐ Back pain

SLEEP DISTURBANCES:
- ☐ Apnea
- ☐ Daytime sleepiness
- ☐ Insomnia
- ☐ Snoring
- ☐ Difficulty falling asleep
- ☐ Morning headache
- ☐ Waking up tired
- ☐ Gasping for air in sleep

HEART:
- ☐ Chest pain
- ☐ Irregular heart rate
- ☐ Varicose veins
- ☐ Poor circulations

RESPIRATORY:
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Sputum production
  - ☐ Clear ☐ Blood ☐ Yellow/Green

GENITO-URINARY:
- ☐ Frequent urinations
- ☐ Blood in urine
- ☐ Painful urinations
- ☐ Poor urinary stream

SKIN:
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Rash

DIGESTIVE SYSTEM:
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Flatulence
- ☐ Nausea/Vomiting

ALLERGIES:
- ☐ Cough
- ☐ Post nasal drip
- ☐ Sneezing
- ☐ Earache
- ☐ Ringing in ears

PATIENT NAME:_____

DOB:_____ **DATE:**_____

ASSOCIATED CONDITIONS: **Please check any conditions you currently have or had in the past year.**

☐ Alcoholism ☐ Anemia ☐ Arthritis ☐ Asthma

☐ Bleeding Disorder ☐ Bronchitis ☐ Cancer ☐ Coronary Heart Disease

☐ Congestive Heart Failure ☐ Diabetes ☐ Depression

☐ Emphysema ☐ Epilepsy (Seizure) ☐ Gout ☐ GERD (Heartburn)

☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ High Cholesterol

☐ Kidney Disease ☐ Kidney Stone ☐ Liver Cirrhosis ☐ Lupus

☐ Migraine Headache ☐ Pneumonia ☐ Prostate Problem

☐ Rheumatoid Arthritis ☐ Stroke ☐ Thyroid Problems

☐ Tuberculosis ☐ Ulcers ☐ Others _____

PREVENTIVE TESTING:

Pneumococcal Vaccination. Yes or No If Yes: When _____, Where _____

Influenza Vaccination: Yes or No If Yes: When _____, Where _____

Last Colonoscopy: Date _____ Results: _____ Location: _____

Last Hemoccult Test: Date _____ Results: _____ Location: _____

Last Diabetic Eye Exam: Date _____ Results: _____ Location: _____

Last A1c Test: Date _____ Results: _____ Location: _____

Last Mammogram: Date _____ Results: _____ Location: _____

PATIENT NAME: _____

DOB: _____ DATE: _____ Account # _____

SOCIAL HISTORY: Please Check

EDUCATION: ☐ High School ☐ Collage Degree ☐ Some Collage ☐ Trade School
☐ Highest Education Level

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

OCCUPATION: ☐ Disabled ☐ Unemployed ☐ Self Employed ☐ Employed
☐ Student ☐ Homemaker ☐ Retired ☐ Full Time ☐ Part Time

COFFEE: ☐ No ☐ Yes, _____ Cups Daily. ☐ Other Caffeine _____

ALCOHOL: ☐ No ☐ Yes, Type _____ ☐ Minimal Amount ☐ Occasional
☐ Amount: _____ per ☐ Day ☐ Week ☐ Month

DIET: ☐ High Salt Intake ☐ Diabetic Diet ☐ Regular ☐ Other _____

EXERCISE: ☐ Regular Exercise ☐ Irregular Exercise ☐ No Physical Activity

DRUG USE/ABUSE: ☐ No ☐ Yes, How Long _____ When Stopped: _____

SLEEP HABITS: ☐ Normal ☐ Irregular (If Irregular please check appropriate sleep disturbances)

SLEEP DISTURBANCES: ☐ Daytime Sleepiness ☐ Difficulty Falling Asleep ☐ Insomnia
☐ Continuity Disturbances ☐ Early Morning Awakening ☐ Snoring ☐ Sleep Apnea

SMOKING STATUS:

☐ **NEVER** ☐ **TRYING TO QUIT** ☐ **COUNSELED**

☐ **CURRENT:** **Start Date** _____ **Cigarettes Per Day** _____

☐ **FORMER:** **Quit Date** _____ **No Of Years Smoked** _____

PATIENT NAME: _____

DOB: _____ **DATE:** _____ **Account #** _____

FAMILY HISTORY:

CANCER	☐ Mother	☐ Father	☐ Siblings	☐ Uncle	☐ Aunt	☐ Children
DIABETES	☐ Mother	☐ Father	☐ Siblings	☐ Uncle	☐ Aunt	☐ Children
HEART DISEASE	☐ Mother	☐ Father	☐ Siblings	☐ Uncle	☐ Aunt	☐ Children
HYPERTENSION	☐ Mother	☐ Father	☐ Siblings	☐ Uncle	☐ Aunt	☐ Children
KIDNEY DISEASE	☐ Mother	☐ Father	☐ Siblings	☐ Uncle	☐ Aunt	☐ Children
RESPIRATORY PROBLEMS	☐ Mother	☐ Father	☐ Siblings	☐ Uncle	☐ Aunt	☐ Children

OTHER _____

_____

SURGICAL HISTORY:

Please list all previous surgeries and dates

1. _____
2. _____
3. _____

MEDICATION	DOSE	FREQUENCY

ALLERGIES

Authorization For Release Of Protected Health Information

I authorize _____ **to release information listed below to:**
Pulmonary Medical Consultants PA
Mustafa Naeem M.D.
27721 Tomball Pkwy Ste 300
Tomball, Texas 77375
PH (281) 357-1300 FAX (281) 357-1309
EMAIL: fax@lungdoctexas.com

Patients Name: _____ **DOB** _____

Social Security # _____ **Date of Service** _____

Information to be released

☐ Emergency Room	☐ History and Physical	☐ Consultation Report
☐ Operative Reports	☐ Radiology Reports	☐ Radiology films
☐ Lab work	☐ Pathology Report	☐ Discharge Summary
☐ Billing Records	☐ Other _____	

This information is being released for the following purpose:

☐ Continuation of care	☐ Insurance Disability Services	☐ Litigation
☐ Other _____		

I understand that I may revoke the authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180 days) from the date of my signature unless specified in writing here: _____
I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and states privacy regulations.
To the party receiving the information: **This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or is otherwise permitted to such regulations. A general authorization of the release of information or other information is not sufficient for this purpose.**

_____ _____
Signature of Patient or legally authorized representative — Date

_____ _____
Relationship to Patient — Print name of legally authorized representative

_____ _____
Patient or legally authorized representative Driver License # — Date

_____ _____
Witness printed name / signature — Date

Pulmonary Medical Consultants

27721 Tomball Pkwy Ste 300 Tomball, Tx 77375
Phone: (281) 357-1300 Fax: (281) 357-1309

PATIENT NAME:_____

DOB:_____ **DATE:**_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/ FAMILY MEMBERS:

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician of staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical development I stipulate that these rules can be waived.

_____I do not authorize the practice to release any or all information concerning my medical care to any individual except as set forth above.

_____I do authorize the practice to verbally release any or all information concerning my medical care to the following individuals:

Name	**Relationship**
Name	**Relationship**
Name	**Relationship**
Patient signature	**Date**
Witness	**Date**

CANCELLATION & NO-SHOW POLICY

We strive to render excellent medical care to you and the rest of our patients, so we understand the situations arise in which you must cancel your appointment. In order to provide all of our patients with the highest level of care and access we request that all patients that need to cancel their appointment provide more than 24-hour notice. This will enable to us better utilize available appointments for our patients.

Appointments cancelled with less than 24-hours or if the patient No-shows without notification may be subject to cancellation fee. The cancellation fee is provided below.

Fee ----------$25.00

The cancellation and No-show are the sole responsibility of the patient and must be paid in full before the next scheduled appointment.

Please contact our office should you have any questions regarding the Cancellation and No-show fees we will be glad to assist.

_____ _____

Patient Name (please print) **Date of Birth**

_____ _____

Patients signature or patient Representative **Date**

ASSIGNMENTOF BENEFITS FORM

FINANCIAL RESPONSIBILITY:

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Dr Mustafa Naeem for any charges not covered by my heath care benefits. It is my responsibility to notify the office of Dr Mustafa Naeem 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 Dr Mustafa Naeem and./or my heath care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and /or supplies received.

ASSIGNMENT OF BENEFITS:

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Dr Mustafa Naeem for all covered medical services and supplies provided to me during all courses of treatment and care provided by Dr Mustafa Naeem. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Dr Mustafa Naeem, and will constitute a continuing authorization, maintained on file with the office of Dr Mustafa Naeem, which will authorize and allow for direct payment to Dr Mustafa Naeem of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/ or care provided to me by Dr Mustafa Naeem.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/ or supplies provided to me by Dr Mustafa Naeem. A copy of authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity if requested. The original authorization will be kept on file by the office of Dr Mustafa Naeem.

Patient/ Insured (Printed Name)	Date of Birth	Social Security Number
Patient/ Insured (Signature)	Date of Signature	
Witness (Signature)	Date of Signature	

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's authority