Patient's Name:_____ Date of Birth: ____/____/____

☐ Said Soubra, MD ☐ Shantanu Naik, MD ☐ Abhishek Vidavalli, MD
☐ Harsh Babbar, MD ☐ Ellen Middleton, MD ☐ Naomi Mathew, MD ☐ Khan, Balai

Williamson Pulmonary & Sleep Associates

PATIENT/FAMILY MEDICAL HISTORY FORM

(Use BLACK ink only)

Today's Date ___/___/___

Pharmacy Name & Address:

_____

Phone Number with Area Code: _____

Personal Medical History Height:_____Ft. ____In. Weight: _____
(Office Use ONLY: T_____ HR_____ 02%_____ LF_____RR_____BP_____N_____)
Medications: List all current medications and dosages or provide a list. If no current medications please write N/A in the first box.

Medication	Strength (mg, units)	Directions(# of tabs/puffs, etc. How many times per day?

MEDICATION ALLERGIES: ☐ No,I do not have any medication allergies
List any allergies to medications and specify what kind of reaction You've experienced from taking medication

Medication:	Reaction:
Medication:	Reaction:

Patient's Name:_____ Date of Birth: ____/____/____

Patient/Family Medical History (Continued)

Patient Past/Current Medical History **NONE** ☐

Please place an (X**) by all the conditions listed below that you have been diagnosed with in the **past or present**

☐ Asthma	☐ Tuberculosis	☐ Heart Disease	☐ Diabetes	☐ Thyroid Disease
☐ Chronic	☐ Bronchitis	☐ COPD	☐ Emphysema	☐ Pulmonary HTN
☐ Snoring	☐ Pneumonia	☐ Allergic Rhinitis	☐ Stroke	☐ Reflux/GERD
☐ Anemia	☐ Sleep Apnea	☐ Restless Legs	☐ Heart Attack	☐ High Blood Pressure
☐ Lung Mass	☐ Lung Nodule	☐ Cardiac Stent	☐ Kidney Disease	☐ High Cholesterol
☐ Chronic Cough	☐ Shortness of Breath		☐ Pulmonary Fibrosis	☐ Pulmonary Embolism
☐ Pleural Effusion	Cancer (type)_____			

***Please list all other past or present medical conditions you have been diagnosed with that are not listed above:

_____

_____

Previous Surgery/s ☐ **No, I have never had any surgeries**

(Lung, Heart, and ALL other surgeries)

Hospital & City	Reason	Physician Name	Year

Social History

Are you working now? ☐ Yes What is your occupation?

☐ No What was your occupation? ☐ Retired ☐ Unemployed

Have you ever been exposed to Asbestos, dust or strong fumes? ☐ Yes ☐ No

If YES, please describe:

_____

_____

Have you ever smoked cigarettes or any other type of tobacco products?

☐ Yes ☐ No If Yes: Do you still smoke or use tobacco products? ☐ Yes ☐ No

At what age did you start smoking or use tobacco products? _____

At what age did you stop smoking or use tobacco products? _____

How many packs a day do/did you smoke?_____

What type/s of tobacco products other than cigarettes have you used?_____

Do you keep animals at home? ☐ Yes ☐ No If Yes, What type?_____

Do you drink caffeine? ☐ Yes ☐ No If Yes, how often & how much?_____

Patient's Name:_____ Date of Birth: ____/____/____

Do you consume alcoholic beverages? ☐ Yes ☐ No

If Yes, How often? How many times per: _____Week _____Month _____Year

If Yes, How many drinks do you have on a typical day when you are drinking? _____

Do you consider yourself an Alcoholic? ☐ Yes ☐ No

Do you use recreational/illicit drugs? ☐ No, Never ☐ Yes, In the past ☐ Yes, currently

If Yes, please describe:

_____

_____

Family Medical History

☐ No Known Family History of Medical Illness/Disease

☐ I was adopted

Please specify which relative AND distant relatives. Please specify if they are on (P) paternal side or (M) maternal side (Ex. Write a P or M next to each relative you list)

Disease	Relative	Other Diseases	Relative
Asthma			
Emphysema			
COPD			
Lung Cancer			
Heart Disease			
Blood Clotting Disorder			
High Blood Pressure			
High Cholesterol			
Cancer & Type			
Cancer & Type			
Cancer & Type			

Preventative Care

Have you had a flu shot since the most recent September 1st? ☐ Yes ☐ No

Date: ___/___/___ Location: _____

Have you had a Pneumonia shot in the past 10 years? ☐ Yes ☐ No

Date: ___/___/___ Location: _____

Have you received a TB Skin Test? ☐ Yes ☐ No

Date: ___/___/___ Location: _____

Results: ☐ Positive ☐ Negative

If Positive was a chest X-ray done? ☐ Yes ☐ No Results: ☐ Positive ☐ Negative

Have you ever received treatment for TB? ☐ Yes ☐ No

Patient's Name:_____ Date of Birth: ____/____/____

Review of Systems: ☐ **If NONE check here**

Please place an (**x**) next to any symptoms you are currently experiencing

System	Symptoms
General	___Fever ___Sweat/chills ___Weakness ___ Weight Change ___Fatigue ___Irritability
Sleep	___Snoring ___I have been told I quit breathing in my sleep ___Choking/Gasping for air at night ___Restless Legs ___Excessive Sleepiness ___Nightmares
Eyes	___Redness ___Excessive tearing ___Discharge ___ Sensitivity to light ___Visual Discharges
Ears	___Pain ___Deafness ___Ringing in Ears ___Vertigo ___Itching ___Discharge
Nose	___Frequent Colds ___Sinus Infections ___Frequent Nosebleeds ___Snoring
Mouth/Throat	___Dental Problems ___Jaw Pain or clicking ___Postnasal Drainage ___Dry Mouth___Sore Throat ___Hoarseness ___Frequent Throat clearing
Endocrine	___Thyroid Disorder ___Goiter ___Feel hot or cold when others are not
Respiratory	___Persistent cough ___Sputum/Phlegm ___Wheezing ___Coughing up blood ___Pain when breathing ___Shortness of Breath ___Difficulty breathing while laying flat
Cardiovascular	___Chest Discomfort ___Swelling of Ankles ___Palpitations ___Lightheadedness ___Blood Clots ___Fainting
Gastrointestinal	___Heartburn ___Abdominal Pain ___Constipation ___Bloody stools ___Black Stools ___Jaundice ___Difficulty Swallowing ___Nausea/Vomiting/Diarrhea
Genitourinary	___Difficulty Urinating ___Painful Urination ___Frequent urination ___Sexual Problems ___Kidney Stones ___WOMEN: Date of last menstrual cycle _____
Musculoskeletal	___ Limited Movement of Joints ___Swelling of Joints ___Painful Joints ___Back Pain ___Neck Pain
Skin	___Color Changes ___Skin Eruptions ___Itching ___ Scaling ___ Bruise Easily ___Hives
Neurological	___ Frequent Headaches ___Dizziness ___Numbness ___Muscle Weakness ___Forgetfulness
Psychiatric	___Anxiety ___Depression ___Hallucinations

Patient's Name:_____ Date of Birth: ____/____/____

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For your appointment please bring the following with you:

- Completed New Patient Packet (enclosed paperwork)
- Insurance cards and Photo ID
- Detailed list of medications (dosages and frequency)
- A copy of your Advance Directive, Living Will, Surrogate Decision, and/or Durable Power of Attorney documents
- Co-Payment or coinsurance (we accept cash, check, credit card (Visa, MC, & AMEX)
- DME (Medical supply company) information including name, address, phone number, and fax
- SLEEP PATIENTS: Bring a copy of your CPAP/BIPAP download or one can be faxed to our office
- Bring a disc of any CT scan and/or chest X-ray (within last year) from facilities that are NOT a part of Seton Medical Center Harker Heights or Cedar Park Regional Medical Center

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1) Co-payments or co-insurance fees are expected at the time of each visit.
2) Any forms or documents that require a physician's signature will be a $10.00 fee at the time of submission or you may waive the fee by scheduling an appointment.

By signing, I agree to the above policies: _____

Date:_____

Should you have any questions please don't hesitate to call us at 254-618-1090 for the Harker Heights Clinic or 512-623-5299 for the Cedar Park Clinic. If you would like to contact our Certified Medical Assistant please call the appropriate clinic and ask to speak with them.

Thank you for choosing Williamson Pulmonary & Sleep Associates in continuing your medical care and we look forward to meeting you.

Patient's Name:_____ Date of Birth: ____/____/____

Patient Registration Form

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Today's Date ___/___/___

Patient's Name: _____ Preferred Name: _____

Social Security # ____-____-____ Sex: Male Female

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email address: _____

Consent to Web Enable Access to Patient Portal ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name: _____ Spouse's Date of Birth:_____
(If not applicable leave blank)

Ethnicity (Please Circle): Hispanic/Latino Non Hispanic Unreported/Refused to Report

Race (Please Circle): American Indian/Alaskan Native Asian Native Hawaiian/Other Pacific Black/African American White Other Race Other Pacific Islander Unreported/Refused to Report

Language: English Spanish Indian Russian
Other:_____

Patient's Name:_____ Date of Birth: ____/____/____

Employment

Employer (Please Circle): _____

Full Time Part Time Retired Student None

Occupation: _____

Employer Address: _____

City:_____ State:_____ Zip:_____ Phone:_____

Physician/Pharmacy Information

Primary Care Physician: _____Phone:_____

Referring Physician: _____Phone:_____

Preferred Pharmacy: _____Phone:_____

Responsible Billing Party

(**ONLY** complete if the responsible billing party is different from the patient)

Name: _____ Date of Birth____/____/____

(Last) (First) (MI)

Address: _____ City:_____ State:_____ Zip:_____

Social Security #:___/___/___ Phone:_____ Sex: ☐ Male ☐ Female

Relationship to Patient: ☐ Spouse ☐ Partner ☐ Durable Power of Attorney

☐ Other:_____

Primary Insurance Information

☐ **No I do not have Medical Insurance**

Insurance Name: _____

Employer:_____

Policy Holder Name: _____

Date of Birth: ____/____/____

Social Security Number: _____/_____/_____

Member ID: _____

Group Number: _____

Emergency Contact Information

Name: _____

Telephone: _____

Relationship to Patient: _____

Name: _____

Telephone: _____

Relationship to Patient: _____

Patient's Name:_____ Date of Birth: ____/____/____

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

Home Telephone:_____

☐ OK to leave a message with detailed information

☐ Leave message with a call back number only Work

Cell Phone:_____

☐ OK to leave a message with detailed information

☐ Leave message with a call back number only Home

Release of Information: I hereby authorize Williamson Pulmonary and Sleep Associates P.A. to release my information to any medical provider such as a physician, medical equipment company, or hospital as well as any insurance company and/or responsible billing party. This information may include diagnosis, records of any treatment, or any examinations rendered. In addition to the above release, I authorize Williamson Pulmonary and Sleep Associates P.A. to release any information to:

Please PRINT name/s, phone number/s, and relation to patient

Name:_____ Phone Number:_____

Relation to patient:_____

Patient Signature:_____Date:____/____/____

Patient's Name:_____ Date of Birth: ____/____/____

Consent to Obtain Medication History from an External Source

I authorize Williamson Pulmonary & Sleep Associates to view any and all of my available Prescription History from and External Source. I am aware that Williamson Pulmonary Sleep Associates uses a secure connection to Surescripts E-Prescriptions to send and receive prescriptions electronically.

Patient Signature:_____Date:____/____/____

Relationship to Patient if not signed by patient_____

Assignment of Benefits

I hereby assign to Williamson Pulmonary and Sleep Associates any insurance or other third-party benefits available for health care services provided to me. I authorize direct remittance of payment of all insurance benefits to Williamson Pulmonary and Sleep Associates for all covered medical services and supplies provided to me during all courses of treatment and care provided by the Williamson Pulmonary and Sleep Associates and /or its affiliated entities. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by Williamson Pulmonary and Sleep Associates. I understand that this assignment of benefits does not relieve my ultimate responsibility for all charges not covered or paid by insurance.

Consent to Treat

I voluntary consent and authorize Williamson Pulmonary and Sleep Associates and /or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf.

By signing below, I agree to the terms of this document which I have read and had the opportunity to ask questions about and I acknowledge that I have the opportunity to request and receive a copy of this office's Notice of Privacy Practices and Financial Policy which explains how my medical and billing information will be used and disclosed.

Patient or Patient's Representative Signature:_____ _____
Date:____/____/____

For Patient Representative ONLY:
My relationship to the patient is _____ and I have signed this consent on the patient's behalf.

Witness: _____ Date:____/____/____

Patient's Name:_____ Date of Birth: ____/____/____

Advanced Directives

Do you have, or would you like to name a Surrogate Decision Maker?

- A surrogate decision maker is a trusted individual who can make medical decisions for you in the event you are not able to make decisions yourself. This is a verbal preference and not a legal document.

☐ **No I do not wish to add a Surrogate Decision Maker**

Yes please add the following Surrogate Decision Maker/s:

Surrogate's Name: _____ Phone: _____

Relationship to Patient: _____

Alternative Surrogate's Name: _____ Phone: _____

Relationship to Patient: _____

Do you have the following? Please check appropriate box/s

- ☐ Advanced Directive to Physician's and Family or Surrogates Living Will
  (If you have a written copy please bring a copy of your form/s with you to our office and allow us to keep a copy in your medical records)
- ☐ Medical/Durable Power of Attorney
- ☐ No, I do not have either of these (If you would like a copy of a the blank forms of the Written Advances Directive, please let us know)

Patient's Name:_____ Date of Birth: ____/____/____

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Authorization to Release Patient Information

Requesting records from Facility/Doctor Name: _____
Phone: _____ Fax: _____
I, _____ authorize this Facility to use or disclose my health information as described below.

1. Information to be used or disclosed (Place and "X" next to all that apply)

___Discharge Summary ___Chest Imaging Results___6 minute walk tests___History and Physical
___Recent Lab Results ____Sleep Study/Titration___Consultation Notes __Office/Doctor Notes
___Compliance Downloads___Chest related Operative Reports___Echocardiograms
___Spirometry testing__Pulmonary Tests___Overnight Oximetry Reports___Other (Please Specify)

_____

Please choose one of the following by placing and "X":

_____I specifically authorize that information related to HIV/AIDS, other sexually transmitted diseases, mental health, and/or substance abuse may be used or disclosed.

_____I do not authorize the use or disclosure of HIV/AIDS, or other sexually transmitted diseases, mental health, and/or substance abuse information.

2. Recipient of Information – The information identified above may be used by, or disclosed to, the following individual/s or organization/s:

Williamson Pulmonary & Sleep Associates

Harker Heights Location
800 W. Central Texas Expressway
☐ **Suite 295**
Harker Heights, TX 76548
Fax: 254-618-1093

Cedar Park Location
1401 Medical Pkwy
☐ **Building C, Suite 125**
Cedar Park, TX 78613
Fax: 254-618-1090

3. Purpose of disclosure – The information identified above will be used for the following purpose/s. _____Continuation of Care _____Transfer of Care
Other
(specify)_____

4. This authorization will expire on _____/_____/_____ (If left blank, this authorization will expire (1) year from the signature date)

I understand that I have the right to revoke this authorization, in writing to the facility, at any time. I understand that a Revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand the information disclosed may be re-disclosed by the recipient and federal or state law may no longer protect the information. I understand my treatment or payment for my treatment cannot be conditioned on signing this authorization.

_____ _____/_____/_____

Signature of Patient or Authorized Representative **Date Signed**

_____

Printed Name of Patient or Authorized Representative

_____

Capacity of Authorized Representative, if applicable

Patient's Name:_____ Date of Birth: ____/____/____

Notice of Privacy Practices

I have received a copy of this Notice of Privacy Practices, I have read it and I had an opportunity to ask questions about it, and I agree to its terms.

_____ _____/_____/_____
Signature of Patient Date Signed

_____
Printed Name of Patient

I, _____, am the patient's authorized representative. My relation to the patient is _____ and I have signed this consent on the patient's behalf.

_____ _____/_____/_____
Signature of Authorized Representative Date Signed

_____
Printed Name of Authorized Representative