

## ARIZONA LUNG AND SLEEP CONSULTANTS

Specializing in Diseases of the Lungs and Sleep Disorders

[www.arizonalung.com](http://www.arizonalung.com)

10290 N 92<sup>nd</sup> Street, Suite 301, Medical Plaza Two  
Scottsdale, AZ 85258

Phone 480-657-8800

Fax 480-661-0149

Thank you for choosing Arizona Lung and Sleep Consultants to provide your health care.

You have an appointment scheduled \_\_\_\_\_ at \_\_\_\_\_ (a.m./p.m.) with:

- |                          |                      |                          |                       |
|--------------------------|----------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | Dr. Robert G. Hooper | <input type="checkbox"/> | Dr. Lawrence E. Slama |
| <input type="checkbox"/> | Dr. Irfan Khalid     | <input type="checkbox"/> | Dr. Aamir Awan        |

Please bring the following information with you to your appointment:

1. Any chest X-rays, CT scans, or other radiologic procedures done during the past year. Our doctors prefer to have the films. If your films were taken at Scottsdale Medical Imaging (SMIL) you can call them to have them delivered to our office. If you have had X-rays done and do not bring them with you, this may delay diagnosing your condition.
2. **If your appointment is for sleep problems and you have had prior sleep studies, please bring copies of the sleep study or have the facility fax us a copy of the entire sleep study.**
3. Health insurance card(s). Please check with your insurance plan to determine if we are contracted with your insurance and "in-network". This is your responsibility prior to the appointment.
4. Co-payment if required by your insurance (the amount is usually specified on your card). We accept VISA, Mastercard, Discover card, American Express and debit cards.
5. The enclosed completed Patient Information form and history form. Please do not mail these to us, bring them to your appointment.

Notify your referring physician to send us records which are pertinent to your visit including any recent blood work, pulmonary function tests, etc.

If you have any questions regarding your appointment please call. Our office hours are Monday through Friday, 8:30 a.m. to 5:00 p.m. and we have an answering service after hours. If you cannot keep your appointment, we ask that you please call us 24 hours in advance to cancel. A new patient consultation is scheduled for an hour. Not giving us advance notice deprives another patient of the opportunity to see our doctors. A "NO SHOW" charge may be billed to you if you fail to notify us that you will not keep this appointment.

Again, thank you for choosing Arizona Lung and Sleep Consultants.

**ARIZONA LUNG and SLEEP CONSULTANTS**  
**(Please Print)**

REFERRING DR. \_\_\_\_\_ REFERRING DR. PHONE NO. \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  MALE  FEMALE

Last Name                      First Name                      MI

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_                      SS# \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_

City                      State                      Zip

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

**PRIMARY INSURANCE**

Ins.Co. Name \_\_\_\_\_  
Policy # \_\_\_\_\_ Grp \_\_\_\_\_  
Relation to patient \_\_\_\_\_  
Insured's name \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_  
Insured's SS# \_\_\_\_\_  
Employer \_\_\_\_\_

**SECONDARY INSURANCE**

Ins.Co. Name \_\_\_\_\_  
Policy # \_\_\_\_\_ Grp \_\_\_\_\_  
Relation to patient \_\_\_\_\_  
Insured's name \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_  
Insured's SS# \_\_\_\_\_  
Employer \_\_\_\_\_

**WHO MAY RECEIVE INFORMATION REGARDING YOUR PROTECTED HEALTH INFORMATION?**

**(CHECK ALL THAT APPLY)**

_____ Spouse	Name: _____
_____ Children	Name(s): _____
_____ Physician	Name(s): _____
_____ Other	Name(s): _____

May we leave messages regarding test results and appointments on your answering machine?  
\_\_\_\_\_ YES      \_\_\_\_\_ NO      If not, how would you like to be contacted: \_\_\_\_\_

The HIPAA Privacy Rules are available in the provider's office. By my signature, I authorize the above list of persons to receive my Protected Health Information per HIPAA requirements. I may revoke this at any time by giving written notification to this provider.

Date: \_\_\_\_\_ Signature \_\_\_\_\_

**Assignment and Release**

I, the undersigned, have insurance coverage and assign directly to Arizona Lung all medical benefits, if any, otherwise payable for all charges whether or not paid by insurance. I hereby authorize the facility to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

In Medicare assigned cases, the Physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date



**PATIENT HISTORY (Check all that apply)**

1.  Asthma  Tuberculosis  Colon polyps  High Cholesterol  
 Bronchitis  Valley Fever  Diabetes  Kidney Disease  
 Emphysema  Heart Burn  Osteoporosis  Bleeding tendencies  
 Pneumonia  Ulcers  Heart Disease  Cancer  
 Hay fever  Hepatitis  Hypertension

2. Childhood Diseases:  Rheumatic Fever  Whooping Cough  Other

3. Tobacco Use Ever?  NO  YES Age started smoking \_\_\_\_\_  
Age quit smoking \_\_\_\_\_  
Type and daily amount \_\_\_\_\_

4. Alcoholic Beverages  NO  YES Type \_\_\_\_\_ Weekly Amount \_\_\_\_\_

5. Have you had any operations?  NO  YES If yes, please list:  
Year \_\_\_\_\_ Operation \_\_\_\_\_  
Year \_\_\_\_\_ Operation \_\_\_\_\_  
Year \_\_\_\_\_ Operation \_\_\_\_\_

6. List other illnesses for which you have been hospitalized (including dates):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Do you have any allergies or sensitivities to medicines or other substances?  NO  YES  
If yes, please list: \_\_\_\_\_

8. Have you ever taken cortisone-type drugs?  NO  YES  
If yes, please list: \_\_\_\_\_

9. Have you ever or are you currently on oxygen?  NO  YES

10. Are you currently using a nebulizer:  NO  YES

11. Have you had exposures to toxic fumes, vapors or dusts?  NO  YES  
If so, please list exposures: \_\_\_\_\_

**FAMILY HISTORY (Check all that apply)**

1. Check illnesses which have occurred in your blood relatives:  
 Allergies  Asthma  Bleeding Tendencies  Cancer  
 Diabetes  Emphysema  Heart Disease  Hypertension  
 Kidney Disease  Stroke  Tuberculosis  Valley fever
2. Father: Alive \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Present health or cause of death \_\_\_\_\_  
Mother: Alive \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Present health or cause of death \_\_\_\_\_  
Sisters: Alive \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Present health or cause of death \_\_\_\_\_  
Brothers: Alive \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Present health or cause of death \_\_\_\_\_

**SOCIAL HISTORY (Check all that apply)**

- Single       Married       Live Alone       Family in Town       Children

**REVIEW OF SYSTEMS (Check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Visual problems     | <input type="checkbox"/> Pain or trouble urinating       |
| <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Trouble starting urine stream   |
| <input type="checkbox"/> Postnasal drip      | <input type="checkbox"/> Blood in urine                  |
| <input type="checkbox"/> Runny nose          | <input type="checkbox"/> Weakness of arms or legs        |
| <input type="checkbox"/> Itchy eyes          | <input type="checkbox"/> Numbness or Tingling            |
| <input type="checkbox"/> Sore Throat         | <input type="checkbox"/> Dizziness                       |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Leg Pain                        |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Fever                           |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sweats                          |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Weight change                   |
| <input type="checkbox"/> Coughing up blood   | <input type="checkbox"/> Trouble sleeping                |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Excessive daytime sleepiness    |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Snoring                         |
| <input type="checkbox"/> Swelling of ankles  | <input type="checkbox"/> Trouble breathing at night      |
| <input type="checkbox"/> Nausea or vomiting  | <input type="checkbox"/> Restless, uncomfortable legs    |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Excessive movement during sleep |
| <input type="checkbox"/> Blood in stool      | <input type="checkbox"/> Sleep walking                   |
| <input type="checkbox"/> Other _____         |  |

Signature \_\_\_\_\_