VIRGINIA PULMONARY ASSOCIATES, P.C.
PATIENT REGISTRATION FORM

(Please Print)

Today's date:	**Primary Care Doctor/Referring Physician:**

PATIENT INFORMATION

Last Name:	First:	Middle:	❑Mr. ❑Mrs.	❑Miss ❑Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell phone no. ( )

City:	State:	ZIP Code:	E-mail Address
Occupation:	Employer:		Employer phone no.: ( )
Preferred Language	Race: ❑White ❑Black ❑Asian ❑Indian/Alaska		Ethnicity: ❑Hispanic
	❑Pac Isle ❑ Other/Multi. ❑Declined		❑Non-Hispanic ❑Declined

INSURANCE INFORMATION

Primary insurance:			Policyholder's Name:	
Policyholder's SSN	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to policyholder: ❑ Self ❑Spouse ❑Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑Self ❑Spouse ❑Child ❑Other Policyholder birth date:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 Virginia Pulmonary Associates, P.C., or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PULMONARY HEALTH QUESTIONNAIRE

Name: ____ Date:__________________

DOB:_________________ Primary Care Physician:________________________________

History
Brief description of present problem/complaint:____

____

Past History
Have you ever had:

_______Asthma _______Emphysema _______Pneumonia _______Cancer
_______COPD _______Diabetes _______High blood pressure _______Stroke
_______Seizures _______Thyroid problem _______Liver problems _______Ulcers
_______Blood clots _______Heart attack _______Heart problems _______Arthritis
_______Kidney Problems _______Bleeding problems

Have you ever had **surgery**?
Date:__________Type of surgery:____
Date:__________Type of surgery:____
Date: _________Type of surgery:____
Date:__________Type of surgery:____

Social History
Do you smoke?_________If yes, how much?______________________When did you quit?____________

Have you ever used marijuana or any other hard drug?___________________________________

Occupation:____

Marital status:__________________ Children?______________________________________

Pets:__________________________ Any recent travel?_____________________________

Allergies
Are you allergic to any medications?____

Are you allergic to anything else? ____

Family History

Relationship	Age (if living)	Age at death	State of health or cause of death
Mother			
Father			
Sisters			
Brothers			
Children			

Virginia Pulmonary Associates , P.C.

Patient Name: ______________________ **DOB:** ______________

Patient Phone #: ______________________ **Pharmacy #:** ______________

Original List Date: ______________________

Medication	Dosage Amount	Frequency	Update	Update	Update
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

DRUG ALLERGIES
1
2
3
4
5
6

VA Pulmonary Associates, P.C.
Notice of Privacy Practices

The Department of Health and Human Services has established a “Privacy Rule” to help insure that person health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclose of your personal health information, but his must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your person health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Print name: ___________________________Signature: ___________________________ Date: ___________

People that we may disclose your personal health information to:

1.____Relationship______________________________
2.____Relationship______________________________
3. ____Relationship______________________________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and in
tegrity in performing service for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!

Virgina Pulmonary Associates, P.C.

Missed Appointment Policy

Due to the increase in the number of no shows and last minute cancellations, please be reminded that our office policy for missed appointments is the following:

- If you need to cancel or otherwise reschedule your appointment, you need to notify the office within 24 hours prior to your appointment.
- If you make your appointment the day before, please let us know the morning of your appointment so we have enough time to add someone else in that time slot.
- If the requirements listed above are not met, you will be subject to a $45.00 fee for each no show/late cancellation appointment.

In order to serve you better and have more availability, we hope that you can understand how imperative it is to notify us if you need to cancel an appointment.

This office policy applies to all insurance carriers, therefore no individual is exempt. If you have any questions or concerns regarding this policy, please inquire with our staff.

Test Results Policy

To receive the results of any tests ordered by Dr. Mortazavi or Dr. Goudarzi, you will need to make a follow-up appointment so they can go over any results with you. Dr. Mortazavi and Dr. Goudarzi do not give any results over the phone.

I have read and understand the above aforementioned office policies and agree to comply with these policies.

Signature:________________________________ Date:____________

Sleep Disorders Center of Woodbridge

Virginia Pulmonary Associates, P.C.

Patient Name ____ Date ______________

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing
Sitting and reading	____________________
Watching TV	____________________
Sitting, inactive in a public place (e.g., theater or a meeting)	____________________
As a passenger in a car for an hour without a break	____________________
Lying down to rest in the afternoon when the circumstances permit	____________________
Sitting and talking to someone	____________________
Sitting quietly after a lunch without alcohol	____________________
In a car, while stopped for a few minutes in traffic	____________________