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# PULMONARY & SLEEP ASSOCIATES OF HUNTSVILLE, P.C.

*Board Certified in Critical Care, Sleep and Pulmonary Medicine*

MISBAH F. SIDDIQUI, M.D.
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## PATIENT HISTORY FORM

Welcome to Pulmonary and Sleep Associates of Huntsville. In order to ensure your best care, it is important that you take the time to complete both sides of this medical questionnaire. Thanks.

Name _____ Date of Birth _____
Referring Doctor _____ Primary Doctor _____
Cardiologists _____ Other Physicians _____
Pharmacy Name _____ Pharmacy Phone Number _____
The reason for your visit: _____

## Past Medical History:

**Past Medical History: (Please Circle All That Apply)** ❑ **None**

*Heart:*
Angina
Atrial Fibrillation
Atrial Flutter
Blood Clots
Cerebrovascular Disease
Congestive Heart Failure
Coronary Disease
Endocarditis
Fast Heart Rate
Heart Attack
Heart Valve Disease
High Cholesterol
Hypertension
Peripheral Vascular Disease
Slow Heart Rate
Stroke
Varicose Veins

*Lungs:*
Asthma
COPD
Sleep Apnea
Use CPAP
Tuberculosis

*Mental:*
Anxiety
Depression

*Gastrointestinal:*
Acid Reflux
Cirrhosis
Crohn's Disease
Diverticulitis
GI Bleed
Hepatitis
Liver Disease
Stomach Ulcers

*Urinary:*
Dialysis
Erectile Dysfunction
Kidney Disease
Kidney Stones

*Skeletal:*
Arthritis
Osteoporosis

*Neurological:*
Fainting
Parkinson's Disease
Seizures

*Hematology/Oncology:*
Anemia
Autoimmune Disease
Blood Transfusion
Brain Tumor
Cancer
Chemotherapy
Radiation Therapy
Hemochromatosis
HIV

*Other:*
Diabetes
Hypothyroidism
Hyperthyroidism
Lupus
Fibromyalgia
Rheumatic Fever (Childhood)

Any Additional Illnesses? _____

**Past Surgical History:** ❑ **None**

❑ Abdominal Surgery
❑ Amputation
❑ Angioplasty
❑ AV Fistula Creation
❑ Aortic Valve Repaired
❑ Aortic Valve Replaced
❑ Appendix Removed
❑ Back Surgery
❑ Bladder Surgery
❑ Brain Surgery
❑ Bronchoscopy
❑ Carotid Artery
❑ Carpal Tunnel
❑ Cataract Removal
❑ Colon Surgery
❑ Defibrillator Implanted
❑ Dialysis Catheter
❑ Gallbladder
❑ Gastric Bypass
❑ Heart Bypass
❑ Hemorrhoid Surgery
❑ Hip Replacement
❑ Hysterectomy
❑ Kidney removed
❑ Kidney Transplant
❑ Knee Arthroscopy
❑ Knee Replacement
❑ Kyphoplasty
❑ Lung Removed
❑ Mitral Valve Repair
❑ Mitral Valve Replaced
❑ Pacemaker Implanted
❑ Pain Epidural Injections
❑ Prostate Surgery
❑ Shoulder Surgery
❑ Sleep Apnea Surgery
❑ Thyroid Surgery
❑ Tonsils Removed
❑ Vascular Surgery

Anesthesia Problems ❑ No ❑ Yes
Surgical Complications ❑ No ❑ Yes
Post Operative Complications ❑ No ❑ Yes

**Vaccinations / Skin Test**

| Vaccine | Month/Year |
|---|---|
| Influenza | |
| Pneumonia | |
| PPD/TB skin test | |

| Medications | Dose | Times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| Medications | Dose | Times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Any allergies to medications, etc.? _____
Reaction: _____

**Please continue on other side**

## Social History:

**History of tobacco use:**

Do you smoke cigarettes / cigars? Y / N

If so, how many per day? _____

How many years have you smoked? _____

If you used to smoke, how long ago did you quit? _____

**History of Alcohol Use:**

Do you consume alcohol? Y / N

If so, how many drinks per week? _____

**Illicit Drug Use:**

Do you use illegal drugs? Y / N

If so, what type and how often? _____

_____

**Marital Status:**(circle one)

Single / Married / Divorced / Widowed

**Children:**

Number of children: _____

**Environmental History:**

Have you ever been exposed to any harmful substances?

| Name of Harmful Substance | # of years |
|---|---|
| | |
| | |

**Occupational Information:**

List all occupations and how long you worked at each:

| Occupation | # of years |
|---|---|
| | |
| | |

## Family History:

| Family Member | Living | Deceased | Age/Age at death | Health Condition or Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Spouse | | | | |
| Siblings | | | | |
| | | | | |
| | | | | |

## System Review: (Please check all that apply.)

**General:** ❑ Fevers ❑ Chills ❑ Night sweats ❑ Weight loss ❑ Weight gain ❑ Headaches

**Pulmonary:** ❑ Shortness of breath ❑ Cough ❑ Wheezing ❑ Phlegm ❑ Cough up blood

**Sleep:** ❑ Difficulty in sleeping ❑ Snoring ❑ Morning headaches ❑ Daytime sleepiness ❑ Stop breathing during sleep

**Eyes:** ❑ Bluriness of vision ❑ Dry eyes ❑ Light sensitivity

**ENT:** ❑ Decreased hearing ❑ Loss of smell ❑ Runny or stuffy nose ❑ Sinus pain/drainage ❑ Sore throat ❑ Thrush ❑ Hoarseness of voice

**Cardiac:** ❑ Chest pains ❑ Palpitations ❑ Heart murmur ❑ Leg Swelling

**Gastrointestinal:** ❑ Nausea ❑ Vomiting ❑ Heartburn ❑ Difficulty to swallow ❑ Abdominal pain ❑ Blood in stool

**Genitourinary:** ❑ Pain with urination ❑ Blood in urine ❑ Frequent Urinary tract infections

**Musculoskeletal:** ❑ Joint pain ❑ Joint swelling ❑ Muscle pain ❑ Back pain

**Hematology:** ❑ Bruise easily ❑ Bleeding disorder ❑ History of blood transfusion ❑ Anemia

**Skin:** ❑ Rashes ❑ Tattoos ❑ Itching ❑ Skin discoloration

**Psychiatric:** ❑ Depression ❑ Anxiety ❑ Suicide attempts

**Neurological:** ❑ Seizures ❑ Paralysis ❑ Dizziness ❑ Numbness/tingling ❑ Memory loss

**Please bring a list of all medications to appointment.**

**Signature:**_____ **Date:** _____

**Pulmonary and Sleep**
**Associates of Huntsville**
725 Madison Street • Huntsville, AL 35801
1041 Balch Road, Suite 175 • Madison, AL 35758

| INITIALS | OFFICE USE ONLY |
|---|---|
| | |

**Date:** _____

| PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First | MARITAL (S M W D SEP) | DATE OF BIRTH | AGE | SEX |
|---|---|---|---|---|
| | | | | |

RACE: ❑ AFRICAN AMERICAN ❑ ASIAN ❑ CAUCASIAN / WHITE ❑ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ❑ AMERICAN INDIAN / ALASKA NATIVE ❑ DECLINED ❑ UNKNOWN

| PRIMARY LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER _____ | ETHNICITY: ❑ HISPANIC ❑ NON-HISPANIC ❑ DECLINED ❑ UNKNOWN |
|---|---|

| ADDRESS | CITY, STATE & ZIP |
|---|---|
| | |

| SOCIAL SECURITY NO. | MAIN PHONE NO. ( ) | SECONDARY PHONE NO. ( ) | EMAIL |
|---|---|---|---|
| | | | |

| OCCUPATION (INDICATE IF STUDENT) | EMPLOYER | HOW LONG EMPLOYED? | RELIGION (OPTIONAL) |
|---|---|---|---|
| | | | |

| EMPLOYERS ADDRESS | CITY, STATE & ZIP |
|---|---|
| | |

| HUSBAND, WIFE, PARENT OR GUARDIAN NAME | DATE OF BIRTH | SSN |
|---|---|---|
| | | |

| EMPLOYER OF ABOVE NAME | CITY & STATE | ZIP CODE | BUSINESS PHONE NO. ( ) |
|---|---|---|---|
| | | | |

| PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE | RELATIONSHIP | HOME TELEPHONE NO. ( ) | BUSINESS PHONE NO. ( ) |
|---|---|---|---|
| | | | |

| ADDRESS | CITY, STATE & ZIP |
|---|---|
| | |

| REFERRING PHYSICIAN | | | |
|---|---|---|---|
| ADDRESS | CITY & STATE | ZIP CODE | PHONE ( ) |
| | | | |
| **FAMILY PHYSICIAN** | | | |
| ADDRESS | CITY & STATE | ZIP CODE | PHONE ( ) |
| | | | |

PERSON RESPONSIBLE FOR BILL: _____
IF OTHER THAN PARENT, S.S.# _____
ADDRESS OF RESPONSIBLE PARTY _____

| PRIMARY INSURANCE CO. | NAME OF POLICY HOLDER | POLICY HOLDER DOB | COPAY |
|---|---|---|---|
| | | | |
| CONTRACT NUMBER | GROUP NUMBER | EMPLOYED BY: | |
| | | | |
| SECONDARY INSURANCE CO. | NAME OF POLICY HOLDER | POLICY HOLDER DOB | COPAY |
| | | | |
| CONTRACT NUMBER | GROUP NUMBER | EMPLOYED BY: | |
| | | | |
| OTHER INSURANCE | NAME OF POLICY HOLDER | POLICY HOLDER DOB | COPAY |
| | | | |
| CONTRACT NUMBER | GROUP NUMBER | EMPLOYED BY: | |
| | | | |

## AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Pulmonary and Sleep Associates of Huntsville for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

## AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Pulmonary and Sleep Associates of Huntsville to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

Signature: _____ Date: _____

**SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER**

REV 04/2018

Pulmonary & Sleep Associates of Huntsville

## DISCLOSURES & PRIVACY PRACTICES

**Patient Name:** _____ **DOB:** _____

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 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:

| | Phone Number | OK to leave message with detailed information | Leave message with call-back number only |
|---|---|---|---|
| Home Phone | | | |
| Work Phone | | | |
| Cell Phone | | | |

I acknowledge that I have received a copy of the Notice of Privacy Practices and that Pulmonary and Sleep Associates of Huntsville may, at its discretion change the terms and conditions of this notice.

**(Please Initial)** _____

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**Release of Medication History Authorization:**

I give Pulmonary and Sleep Associates of Huntsville permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed as part of my medical records release.

**(Please Initial)** _____

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Pulmonary and Sleep Associates of Huntsville and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

---

Printed Name: _____

Signature: _____ Date: _____

Pulmonary & Sleep Associates
of Huntsville

# FINANCIAL POLICY

**PSA** believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance payment in full is expected at the time of your visit. We do ask for a copy of a picture ID due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **INSURANCE.** We are participating providers with several insurance plans. We will file all insurance claims as a courtesy to you. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay PSA within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayments to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed by PSA are considered covered unless limited by your specific insurance policy.

3. **RETURNED CHECKS** will incur a $50.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $50 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $50 service fee and collections action. All returned checks written to PSA are subject to collections and will be prosecuted by Madison County District Attorney.

4. **BILLING OFFICE**: If you have questions in regard to any of your billing statements, our insurance staff at PSA is available to assist you. CALL 256-883-2110.

5. **CANCELLATIONS OR MISSED APPOINTMENTS**: If you do not cancel your appointment at least 24 hours before, or if you-no-show, we may assess you a $25.00 missed appointment fee that must be paid prior to scheduling another appointment. This charge will not be filed with your insurance.

6. **RESPONSIBILITY FOR PAYMENT**: I understand that I, personally, am financially responsible to PSA for charges not covered by the assignment of insurance benefits. **SELF PAY PATIENTS**. All monies owed are expected on date of service. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. PSA will be happy to assist you with a patient financial arrangement however, the first visit will need to be paid in full prior to any arrangements being made.

7. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby, assign, transfer, and set over directly to PSA sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said office. I authorize PSA to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to PSA. I authorize PSA to release all medical information (including, but not limited to, information on psychiatric conditions, Sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

8. **COLLECTION FEES:** I understand that in the event my account is placed in collections status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the PSA financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ Date:_____

Signature of Patient

# ADVANCED CARE PLANNING

**Patient Name -** _____ **DOB -** _____

This form is intended for you to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy.

Place your initials by only ONE answer:

_____ I do not want to name a health care proxy at this time.

_____ I would like to discuss advanced care planning with my family and will discuss this further with my doctor at a later date.

_____ I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

FIRST Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone: _____ Night-time phone: _____

SECOND Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone: _____ Night-time phone: _____

**Patient's Signature:** _____ **Date:** _____

# PULMONARY & SLEEP ASSOCIATES OF HUNTSVILLE


☐ 725 Madison Street
Huntsville, AL 35801
Phone 256-883-2112
Fax 256-885-0037

☐ Richard M. Sneeringer, M.D. ☐ Misbah F. Siddiqui, M.D.
☐ Murthy S. Vuppala, M.D. ☐ Saketh Shekar, M.D.
☐ W. Alan McCrory, M.D. ☐ Derek E. Wells, M.D.

☐ 1041 Balch Rd.
Suite 175
Madison, AL 35758

☐ 4810 Whitesport Circle SW
Suite 204
Huntsville, AL 35801


## Authorization for Release / Request of Protected Health Information

Patient's name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's phone #: (  ) _____

Date of Request: _____ Date Needed: _____

☐ I authorize Pulmonary & Sleep Associates of Huntsville to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

OR

☐ I authorize Pulmonary & Sleep Associates of Huntsville to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

**Purpose For This Request:** (Check one) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other

**Type Of Records Requested:** (Check one)

☐ Specific Information (Select one or more, as applicable)

| | | |
|---|---|---|
| ☐ Operative report | ☐ History & Physical | ☐ Consult |
| ☐ Laboratory test results | ☐ X-ray reports | ☐ Discharge Summary |
| ☐ Office Notes | ☐ Pulmonary Function test | ☐ Sleep records |
| ☐ Other _____ | | |

☐ All medical records related to a specific illness or injury
☐ All medical records

_____
Specify illness / injury  Date(s) of treatment

Physician Signature: _____

### AUTHORIZATION VALID FOR THIS REQUEST ONLY

*I understand that:*

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, STD's (sexually transmitted diseases), mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

**NOTE: Medical records are faxed in cases of medical necessity only.**

Signature of Patient _____ Date _____

Witness _____

Date Mailed _____

# The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 visualize 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 Public Area (i.e., meeting/ theater) | _____ |
| As a passenger in a car for an hour without a break | _____ |
| Lying Down to rest in the afternoon, when circumstances permit | _____ |
| Sitting and Talking to someone | _____ |
| Sitting Quietly after lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in Traffic | _____ |

**Total: _____**

**NAME:_____ DOB:_____**