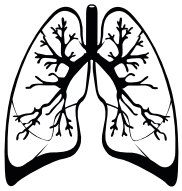

ALBA PULMONARY GROUP

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Phone: 480.759.1027 | Fax: 480.686.9204
www.albapulmonary.com

PATIENT REGISTRATION FORM

(PLEASE PRINT and Fill OUT All FORMS COMPLETELY)

Today's Date: _____

Patient Name:_____ DOB:_____

Address:_____
Street Address City State Zip

Home #:_____ Cell #::_____ Work #::_____

Email:_____

Race: ☐ Native American or Alaska Native ☐ African or African American ☐ Asian or Asian American
☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander ☐ Declined

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

Emergency Contact:_____ PH #_____

PCP:_____ PH #_____ Fax #_____
Primary Care Doctor

Pharmacy Name:_____ PH #_____
Cross Streets

How did you hear about our office?_____

Primary Insurance: _____ Effective Date: _____ / _____ / _____

Member / Policy # _____ Group #_____

Policy Holders Name:_____ Relationship:_____

Policy Holder's Date of Birth: _____ / _____ / _____ Policy Holder's Employer:_____

Secondary Insurance: _____ Effective Date: _____ / _____ / _____

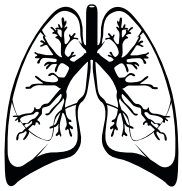
Member / Policy # _____ Group #_____

Policy Holders Name:_____ Relationship:_____

Policy Holder's Date of Birth: _____ / _____ / _____ Policy Holder's Employer:_____

Acknowledgment: I certify that the above information is true and correct. I hereby authorize release of any and all medical information that above named insurance carrier (s) in order to process a claim for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges accumulated from any missed appointments that were not canceled by the patient at least 24 hours prior to my scheduled appointment. In the event of default and the account is placed with a collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed with the agency and interest accrual of 10% per year on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs that occur.

Patient Signature:_____ Date: _____ / _____ / _____



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MEDICAL HISTORY FORM

Today's Date: _____

Patient Name:_____ DOB:_____

Advanced Directives:
Do you have an Advanced Medical Directive / Living Will? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

Social History:

Do you smoke? ☐ Yes ☐ No Packs/day_____ How many years?_____
Did you ever smoke? ☐ Yes ☐ No Packs/day_____ How many years?_____
Have you ever quit? ☐ Yes ☐ No If yes, when and for how long did you quit?_____
How did you quit?_____
Do you use tobacco products other than cigarettes? ☐ Yes ☐ No Which ones?_____
Does anyone smoke in your household? ☐ Yes ☐ No
Do you drink alcohol ☐ Yes ☐ No If yes, amount per week?_____
Have you ever used illegal substances? ☐ Yes ☐ No
Have you ever had a DUI or DWI? ☐ Yes ☐ No
Have you ever experienced difficulty with alcohol, drugs or other substance use? ☐ Yes ☐ No

Hobbies: ☐ Hiking ☐ Biking ☐ Carpentry ☐ Other (Please list any activities that involve exposure to outdoors)

_____

_____

Pets: ☐ Dogs ☐ Cats ☐ Birds ☐ Other_____
Do you take care of birds (pigeons, chickens)? ☐ Yes ☐ No
Recent Travel (Where **outside** of the US) _____

_____

Where did you grow up?_____
How long have you lived in the Phoenix area?_____
Do you live on a farm? ☐ Yes ☐ No

Occupational History: Current occupation_____
Exposure to: ☐ Asbestos ☐ Fumes ☐ Dust
(Please list previous occupations - include approximate dates of employment)

1._____ 2._____

3._____ 4._____

MEDICAL HISTORY FORM Continued

Patient Name:_____ DOB:_____

Medication List ☐ NONE

Name of Medication	Dosage	How often do you take it	Date Started

Check if you use any of the following devices: ☐ NONE

☐ Oxygen-Flow rate _____ l/min How often? _____ Date Started: _____

☐ CPAP or ☐ BIPAP (Pressure _____cm H2O) Date started:_____

☐ Spacer with inhaler (Aerochamber, Ellipse, Inspires, etc.) Date started:_____

☐ Nebulizer (breathing treatment via SVN machine) Date started:_____

Allergies to Medications or Others

Name of Medication/Other	Type of Reaction	Date Started

Immunizations:

☐ Flu shot (influenza) Date:_____ ☐ Pneumovax Date:_____

☐ When was your last TB skin test Date:_____

MEDICAL HISTORY FORM Continued

Patient Name:_____ DOB:_____

List all Physicians you see on a regular basis and reason:

1._____ 2._____

3._____ 4._____

List All and Current Health Problems ☐ None	Date Started

List All Lifetime Surgeries ☐ None	Date

Family History (blood related)

☐ Adopted or do not know family history

If your mother or father is deceased, what caused his/her death? M:_____ F:_____

If any of your siblings are deceased, what caused his/her death?_____

Please check if any of the following apply to blood related kin, indicate which family member(s):

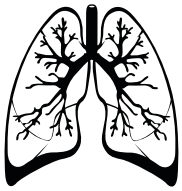
☐ COPD / Emphysema _____ ☐ Asthma _____

☐ Tuberculosis (TB) _____ ☐ Cancer (What type)? _____

☐ Heart disease _____ ☐ Diabetes _____

☐ Sleep disorders _____ ☐ Bleeding/clotting problem _____

☐ Other Lung diseases (specify) _____



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REVIEW OF SYMPTOMS

Today's Date: _____ Patient Name:_____ DOB:_____

Do you CURRENTLY or FREQUENTLY suffer from or have the difficulty with any of the below? Please fill the bubbles

GENERAL

Headache	❍ Yes ❍ No
Unusual fatigue	❍ Yes ❍ No
Loss of appetite	❍ Yes ❍ No
Fever or chills	❍ Yes ❍ No
Night sweats (drench sheets/clothes)	❍ Yes ❍ No
Weight loss lbs Time frame?	❍ Yes ❍ No
Weight gain lbs Time frame?	❍ Yes ❍ No

EARS, NOSE, THROAT, MOUTH

Ear pain/pressure	❍ Yes ❍ No
Sinus problems, post nasal drip	❍ Yes ❍ No
Hoarseness	❍ Yes ❍ No
Frequent clearing of throat	❍ Yes ❍ No
Ulcer of tongue or mouth	❍ Yes ❍ No
Sore throat	❍ Yes ❍ No

CARDIOVASCULAR (RESPIRATORY)

High Blood pressure	❍ Yes ❍ No
Chest pain of exercise (angina)	❍ Yes ❍ No
Irregular beat or palpitation of heart	❍ Yes ❍ No
Heart murmur	❍ Yes ❍ No
Swelling or edema of ankles	❍ Yes ❍ No
History of heart attack	❍ Yes ❍ No
History of enlarged heart (CHF)	❍ Yes ❍ No

LUNGS (RESPIRATORY)

Asthma, wheezing	❍ Yes ❍ No
Cough for more than 3 weeks	❍ Yes ❍ No
Cough, new problem	❍ Yes ❍ No
Cough up blood	❍ Yes ❍ No
Chest tightness or discomfort	❍ Yes ❍ No
Tuberculosis I PPD+ (positive skin test)	❍ Yes ❍ No
COPD I Emphysema	❍ Yes ❍ No
Recurrent bronchitis	❍ Yes ❍ No
Shortness of breath (SOB)	❍ Yes ❍ No
Exposure to asbestos or other occupational hazard	❍ Yes ❍ No
Required life support/mechanical ventilation (respirator)	❍ Yes ❍ No

HEMATOLOGIC

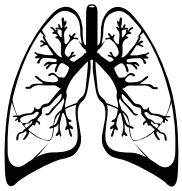
Easy bleeding/bruising	❍ Yes ❍ No
Anemia (low blood count)	❍ Yes ❍ No
Ever had a blood clot in legs or lungs	❍ Yes ❍ No
Blood transfusion	❍ Yes ❍ No
Swollen lymph nodes anywhere	❍ Yes ❍ No

GASTROINTESTINAL

Blood in urine	❍ Yes ❍ No
Kidney or bladder problems	❍ Yes ❍ No
Difficult or painful swallowing	❍ Yes ❍ No
Acid reflux ("Heartburn")	❍ Yes ❍ No
Regurgitation	❍ Yes ❍ No
Belching	❍ Yes ❍ No
Hiatal hernia	❍ Yes ❍ No
Stomach/Intestinal ulcer	❍ Yes ❍ No
Abdominal pain	❍ Yes ❍ No
Nausea or vomiting	❍ Yes ❍ No
Vomit blood/Black bowel syndrome	❍ Yes ❍ No
Blood or mucous in the stool	❍ Yes ❍ No
Liver disease	❍ Yes ❍ No
Hepatitis	❍ Yes ❍ No
Jaundice	❍ Yes ❍ No

NEUROLOGICAL/SLEEP

Snoring	❍ Yes ❍ No
Stop breathing when sleeping	❍ Yes ❍ No
Fall asleep easily during the day	❍ Yes ❍ No
Anxiety	❍ Yes ❍ No
Depression	❍ Yes ❍ No
Unusual dizziness, fainting, or loss of consciousness	❍ Yes ❍ No



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FINANCIAL AGREEMENT

BY PLACING MY SIGNATURE ON THIS PAGE I AGREE TO THE FOLLOWING:

- I am consenting to treatment and services by ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC.
- I understand I am financially liable for all services performed whether or not paid by insurance.
- I authorize my insurance company to make payments directly to ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC.
- I authorize my health care provider to release all information necessary to secure payment of benefits.
- I understand I am responsible for confirming and understanding my insurance company's coverage limitations and policies, including my obligation for deductibles, co-insurance and co-payments.
- I understand all payments are due at the time of service, including co-pays, deductible, balances and co-insurance.
- I understand that if I do not have insurance coverage, the full payment for services is due at the time services are rendered, unless payment arrangements are made (payment plan).
- I understand it is my responsibility to inform billing department of any changes in insurance coverage immediately. I understand I am responsible for charges if correct insurance is not provided and billed timely.
- I agree to pay all cost of collection, and reasonable attorney's fees.
- I understand and agree to pay $25 fee for all returned checks and missed appointments.
- I understand there is a fee for FMLA and/or disability paperwork. A fee of $25 is due at the completion of paperwork. An appointment sometimes is needed to fill out paperwork accurately. Please allow 10 business days for forms and medical records to be completed.

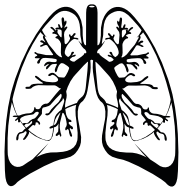
_____ _____

Patient/Legal Representative's Signature Date

_____

Print Patient/Legal Representative's Name

!!!!!IF YOUR INSURANCE HAS CHANGED SINCE YOUR LAST VISIT, WE NEED A COPY OF YOUR NEW INSURANCE CARD THANK YOU!



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ DOB:_____

Maiden/Former Name:_____ SSN:_____ - _____ - _____

Address:_____
Street Address City State Zip

By signing below, I hereby release my medical records:

To:_____
Dr./Facility's Name

_____
Phone Number

_____
Fax Number

From:_____
Dr./Facility's Name

_____
Phone Number

_____
Fax Number

Please send the following information:_____

_____

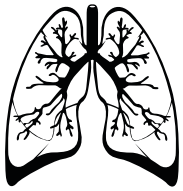
_____

By signing below, I understand that ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC. has no responsibility for the use of distribution of this information by the party to whom it is released. I release ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC. from all liability which may arise from Edgar Bekteshi, MD PLLC compliance with this request to release records.

By signing below, I authorize ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC to transmit this information by facsimile transmission (fax), and release ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC. from any liability for breach of confidentiality, misdirection of transmission or failure receive transmission of records when transmitted by fax.

_____ _____
Patient/Legal Representative's Signature Date

_____
Print Patient/Legal Representative's Name



ALBA PULMONARY GROUP
EDGAR BEKTESHI, MD

Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth:_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed:_____ Date:_____/_____/_____

Witness:_____ Date:_____/_____/_____

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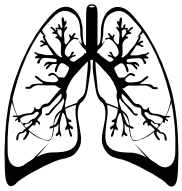

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC. which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgment.

_____ _____
Patient/Legal Representative's Signature Date

_____
Print Patient/Legal Representative's Name

FOR OFFICIAL USE ONLY

I, _____ made a good faith effort to obtain written acknowledgment of _____'s receipt of the Notice of Privacy Practices of ALBA Pulmonary Group, Edgar Bekteshi, MD PLLC. However, I could not obtain written acknowledgment because:
(Please check the appropriate box.)

- ☐ Individual refused to sign this Acknowledgment
- ☐ Communications barrier prohibited obtaining written acknowledgment
- ☐ An emergency situation prevented obtaining written acknowledgment
- ☐ Other (please specify)

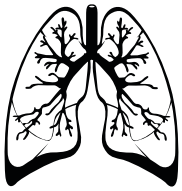
_____

_____

_____

_____

_____



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STOP-BANG OBSTRUCTIVE SLEEP APNEA SCREENING QUESTIONNAIRE

Today's Date: _____

Patient Name:_____ DOB:_____

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

   Yes No

2. Do you often feel tired, fatigued, or sleepy during the daytime?

   Yes No

3. Has anyone observed you stop breathing during your sleep?

   Yes No

4. Do you have or are you being treated for high blood pressure?

   Yes No

5. BMI more than 35 kg/M2?

   Yes No

6. Age over 50 years old?

   Yes No

7. Neck circumference greater than 40cm (17"-Male; 16"-Female)?

   Yes No

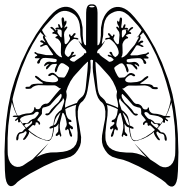
8. Gender male?

   Yes No

Score _____ Number of questions patient answered "yes"

*****High risk of OSA: answering yes to 3 or more questions.**

****Low risk of OSA. answering yes to < 3 questions.**



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EPWORTH SLEEPINESS SCALE

Today's Date: _____

Patient Name:_____ DOB:_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired.

This refers to your usual way of life in recent times.

Use the following scale to choose the most appropriate number for each situation:

Would Never doze **(0)**	Slight chance of dozing **(1)**	Moderate chance of dozing **(2)**	High chance of dozing **(3)**	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in a public place (e.g. cinema or in a meeting)
☐	☐	☐	☐	Being in a car for an hour as a passenger (without a break)
☐	☐	☐	☐	Lying down to rest in the afternoon (when possible)
☐	☐	☐	☐	Sitting and talking to someone
☐	☐	☐	☐	Sitting quietly after lunch (not having had alcohol)
☐	☐	☐	☐	In a car when you stop in traffic for a few minutes.

CALCULATE YOUR RESULT BY ADDING THE VALUES (0,1,2,3) FROM EACH TICK BOX

YOUR RESULT:	

RESULT	WHAT YOUR TEST RESULT INDICATES
< 10	**You are most likely getting enough sleep.** However, if you have noticed a change in your normal sleep routine, you may want to talk to your doctor.
10 - 16	**You may be suffering from excessive daytime sleepiness.** You should see your doctor to determine the cause of your sleepiness and possible treatment.
16 +	**Your are dangerously sleepy.** It is imperative you see your doctor to determine the cause of your sleepiness and investigate treatment.