Welcome and thank you for choosing our practice! Included below is information that will help you with your upcoming appointment.

You will be seeing Dr.Shah / Dr. Kayani.

To ensure that you receive the best possible care, our office will need:

- Picture ID
- Insurance cards
- Pharmacy information
- If your insurance requires a copay, please be prepared to pay it at the time of your visit
- Completed new patient packet
- Referral or medical records pertaining to your visit
- Copies of your most recent chest imaging and lab work

If you have been recently hospitalized or treated at any valley ER or Urgent Care, please inform us and request a copy of your records be sent to our office.

- Our fax number for records is : 480-994-5811
- Our phone number is: 480-994-9838
- Our address is: 7301 East 2nd Street Suite 315
Scottsdale AZ, 85251

<u>Thank you for the opportunity to be part of your healthcare team!</u>

Registration forms

Name:____ D.O.B_____________________

Referring Provider:_____________________ Reason:______________________________

Primary Care Provider: __________________

Have you recently been hospitalized? Yes No If yes, when? __________Where? _______________

Have you recently been to an Urgent Care? Yes No if yes, when?_________ Where?_______________

Have you had any of the following recently?

Test	Where and When?
CHEST XRAY	
CT OF THE CHEST	
CT OF THE SINUS	
LAB WORK	
PULMONARY FUNCTION TEST	
ECHOCARDIOGRAM	

Have you had a flu shot this year? Yes / No / I do not wish to have vaccines
If yes, when? _______________

Have you had a Pneumonia vaccine this year? Yes / No / I do not wish to have vaccines
If yes, when and which one? Prevnar 13:____________ Pneumovax: _________________

Have you had the Covid vaccine? Yes / No

Have you recently traveled outside the United States: Yes No
If yes, where? ________________ When? _______________

Symptoms:

Please check all symptoms you are currently having:

- ☐ Fatigue
- ☐ Chest pain
- ☐ Chest pressure
- ☐ Chest tightness
- ☐ Rapid heart beat
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Headaches.
- ☐ Swelling in legs and feet
- ☐ Numbness in hand and feet
- ☐ Swollen lymph nodes or glands
- ☐ Seasonal allergies
- ☐ Snoring
- ☐ Wake up gasping
- ☐ Sleepiness during the day
- ☐ Restless sleep

Medical History

Please check all that apply:

- ☐ Allergies
- ☐ Alpha 1 antitrypsin
- ☐ Asbestosis
- ☐ Asthma
- ☐ Recurrent bronchitis
- ☐ COPD/ Chronic Bronchitis
- ☐ Emphysema
- ☐ Lung nodules
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Pulmonary Fibrosis/ Lung scarring
- ☐ Sarcoidosis
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Cough
- ☐ Collapsed lung/ Pneumothorax
- ☐ Interstitial lung disease
- ☐ Parkinson's
- ☐ HIV
- ☐ Pleurisy
- ☐ Lung scarring
- ☐ Inhaler use
- ☐ Depression
- ☐ Pleural effusion
- ☐ Sleep Apnea
- ☐ Ulcers
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Seizures
- ☐ Bronchiectasis
- ☐ Sleep apnea
- ☐ Valley Fever
- ☐ Atrial Fibrillation
- ☐ Blood clots/DVT/Pulmonary embolism
- ☐ Congestive heart failure
- ☐ Coronary Artery disease
- ☐ Lupus
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Acid reflux/GERD
- ☐ Diabetes
- ☐ COVID- 19

SURGICAL HISTORY (check all that apply)

- ☐ **Bronchoscopy**
- ☐ **Lobectomy: L or R**
- ☐ **Lung biopsy**
- ☐ **Lung surgery**
- ☐ **Tracheostomy**
- ☐ **Sinus surgery**
- ☐ **Cardiac Cath**
- ☐ **Cardiac Stent**
- ☐ **Pacemaker**
- ☐ **Gall bladder**
- ☐ **Hernia repair**
- ☐ **Dialysis**
- ☐ **Kidney removal**
- ☐ **Lasik**
- ☐ **Lymph node surgery**
- ☐ **Mastectomy**
- ☐ **Thyroidectomy**

Additional Surgeries:

____

____

____

Social history:

Do you use:

☐ Tobacco: Y or N Type of tobacco: Cigarettes Chew Cigar Pipe
Daily average: ________ packs/ pipes/ cans Number of years used: ________
Quit: _______________

☐ Alcohol: Y or N Former Type: Beer Wine Liquor
Daily average: _________glasses/drinks How often? Daily Weekly Monthly

☐ Vape If yes, how often? ________________

☐ Recreational Drugs: Y or N Former Type: _________ How often: _______

☐ Do you exercise: Y or N How often: Daily Weekly Monthly

SPCC

SCOTTSDALE PULMONARY & CRITICAL CARE

MEDICATION LIST

NAME:________________________ DATE: ____________________

DOB:_____________________________

PHARMACY:___________________ CROSS STREETS: _________________________

Any Allergies to medication or reaction:____

____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND THE DOSEAGE

Medication Name	**Strength** (Mg,mcg,etc.)	**How often?** (Once a day….)	**Reason for taking** (Heart, blood pressure, shortness of breath)

AUTHORIZATION TO RELEASE INFORMATION

The purpose of this form is for you, the patient, to give permission for our office to request and receive records on your behalf.

I, ___________________, authorize Dr. Shah / Dr. Kayani to communicate with the persons listed below regarding my care.

1. ___________________________ **PCP:____________________________**
2. ___________________________ **Cardiologist:______________________**
3. ___________________________ **ENT:______________________________**
4. ___________________________ **OTHER:__________________________**

I, ___________________, authorize Dr. Shah / Dr. Kayani to obtain records regarding my healthcare from the following facilities or physicians:

1.______________________________ **3.__________________________________**

2.______________________________ **4.__________________________________**

I, certify that a copy of the **HIPAA NOTICE OF PRIVACY PRACTICES** As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was available to me in office. (Posted in lobby)

Patients Initials: _________________

The purpose of this release: COORDINATION OF CARE

X____ DATE:__________________
Patient / Guardian signature

PLEASE READ AND INITIAL EACH STATEMENT

By signing this contract, I ______________________ agree to all billing terms and conditions listed below.

"All co pays are due at the time of service. If you do not have your co pay, your appointment maybe rescheduled. All co-insurance and deductibles are due within 30 days of receiving your statement. If you cannot pay at the time of service you must contact our billing office to make arrangements. If the account is not paid in full in thirty days, your account will be sent to a collection agency. Should this occur, you will be charged the fees charged to us by the collection agency."

Patients initials_________

"There will be a $25.00 "NO SHOW" fee for any appointment that is missed without notice. There is a cancelation fee of $25.00 for any appointment canceled within 24hrs of appointment time. These fees will need to be paid before any future appointment is scheduled."

Patients initials_________

I give permission for the doctors and staff to communicate messages regarding appointments, referrals, lab results or xrays as follows:

- ☐ **Yes, you may leave a message on my voicemail.**
- ☐ **Other, ____**

I have read and understand this page in its entirety.

X______________________________________ DATE:______________________

Patient / Guardian signature

Registration form

Name:____ Date:________________

Address:__________________________ City:____________ ST:_____ Zip code:_________

Cell phone:__________________ Home phone:________________ SSN:_______________

Email Address_________________ DOB:__________________ Sex: Male or Female

Race	**Ethnicity**
[ ] American Indian	[ ] Hispanic
[ ] Asian	[ ] Not Hispanic or Latino
[ ] African American	[ ] Decline
[ ] Pacific Islander	
[ ] White	**Marital Status**
[ ] Other	[ ] Married [ ] Single
[ ] Decline	[ ] Divorced [ ] Widow

Occupation: ______________________________ Work Phone:______________________
Primary care Physician: _________________________
Referring physician: ___________________________

INSURANCE

Primary Insurance: ________________________
ID: ____________________________ Group: ___________________
Policy holder: ____________________ DOB: ____________________
Address to mail claims: _______________________________________
Secondary insurance: ____________________
ID:_____________________________ Group:___________________

Emergency Contact

Name:_____________________ Relationship:________________ Phone:________________

Address: ________________________ City:_______________ ST:_______ Zip code:________

I herby assign my insurance benefits to be paid to Scottsdale Pulmonary and Critical Care. I understand that I am financially responsible for this bill regardless of coverage. I also authorize the release of information in the processing of the insurance claims. I understand that I am responsible for the charges not covered by of the above agencies. I agree, in the event of nonpayment, to assume the cost of interest, collection and legal fee's (if needed).

Patient Signature: x________________________________ **DATE**:____________________