



SCOTTSDALE PULMONARY & CRITICAL CARE

Town Center Medical Plaza

7301 East Second St, Suite 315

Scottsdale, AZ 85251

Phone: 480-994-9838 Fax: 480-994-5811

Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Email Address: _____

Legal sex: Male Female Occupation: _____ Last four SSN: _____

Race

- American Indian
- Asian
- African American
- Pacific Islander
- White
- Other
- Decline

Ethnicity

- Hispanic
- Not Hispanic
- Decline

Marital Status

- Single
- Married
- Divorced
- Widowed

Seeing Provider: Dr. Alpa Shah Dr. Arooj Kayani Dr. Kimberly Parker

Referring Provider: _____ Reason for Visit: _____

Primary Care Physician: _____ Facility: _____

Emergency Contact:

Name	Relationship	Phone

Patient signature: x_____ Date: _____

I hereby 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 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 fees (if needed).



Disclosure of Health Information Protected Under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO).

I give my consent for Scottsdale Pulmonary and Critical Care to contact me by calling my home or other designated location to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations (TPO).

I give my consent for the use of mail or e-mail to designated locations, including my home, to assist Scottsdale Pulmonary and Critical Care in carrying out the described activities in Treatment, Payment, and Healthcare Operations (TPO).

I give my consent for Scottsdale Pulmonary and Critical Care to use Electronic Medical Record Systems (EMR'S), electronic data interchange programs, and electronic registries to assist in the required documentation and proper storage of a patient's medical record of care.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO).

This consent is good until revoked in writing, except to the extent that disclosure has been made in reliance upon my prior consent. Services are provided without regard to sex, race, color, religion, national origin, or disability.

Patient Signature: x _____ Date: _____



PLEASE READ AND INITIAL EACH STATEMENT

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

_____ I understand “all co-pays are due at the time of service. If I do not have my co-pay, my appointment may be rescheduled. All coinsurance and deductibles are due within 30 days of receiving my statement. If I cannot pay at the time of service, I must contact Scottsdale Pulmonary and Critical Care’s billing office to make alternative arrangements. If the account is not paid in full in thirty days, my account will be sent to a collection agency. Should this occur, I will be charged the fees charged to us by the collection agency.”

_____ I understand “there will be a \$75.00 ‘no show’ fee for any appointment that is missed without notice. There is a cancellation fee of \$50.00 for any appointment cancelled within 24 hours of appointment time. These fees will need to be paid before any future appointment is scheduled.”

_____ I give permission for the doctors and staff to communicate messages regarding appointments, referrals, lab results, or x-rays as voicemail.

Please list alternative approved ways if not specified: _____

I have read and understand this page in its entirety.

Patient/Guardian Signature: x _____ Date: _____



SCOTTSDALE PULMONARY & CRITICAL CARE

Release of Information

Patient Legal Name: _____ DOB: _____

I give my permission for Scottsdale Pulmonary and Critical Care to send and obtain records for the sole purpose of my personal care to the **provider(s)** listed below.

Name	Specialty	Facility

I authorize my provider to discuss and share information regarding my medical care with the **individual(s)** listed below, if requested.

Name	Relationship to Patient

Patient Signature: x _____ Date: _____

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SCOTTSDALE PULMONARY & CRITICAL CARE

Symptom Checklist (please check all that apply):

General

- Chills
- Fatigue
- Fever
- Night Sweats
- Poor Appetite
- Weakness
- Weight Gain
- Weight Loss

Mental Health

- Anxiety
- Depression
- Sleep Issues

Allergies

- Hay fever
- Postnasal Drip
- Runny Nose
- Sensitivity to Pollen
- Watery/Itchy Eyes

Ear, Nose, and Throat (ENT)

- Headaches
- Hoarseness
- Migraines
- Mouth Sores
- Sinus Congestion
- Sore Throat
- Vision Changes

Cardiovascular

- AFIB
- Chest pain
- Heart Attack
- Heart Murmur
- High Blood Pressure
- Palpitations
- Stroke

Gastrointestinal

- Abdominal Pain
- Blood in Stool
- Constipation
- Diarrhea
- GERD
- Nausea
- Heartburn
- Vomiting

Endocrine/Metabolic

- Easy Bruising
- High Cholesterol
- Rash
- Skin Cancer
- Thyroid problems
- Unusual spots

Pulmonary/Respiratory

- Asthma
- Bronchiectasis
- Bronchitis
- COPD
- Cough
- COVID
- Emphysema
- History of Respiratory Infections
- Inhaler use
- Interstitial Lung Disease
- Lung cancer
- Lung Nodules
- OSA
- Pleurisy
- Plural Effusion
- Pneumonia
- Pneumothorax
- Pulmonary Fibrosis
- Sarcoidosis
- Shortness of Breath
- Sputum/Phlegm Production
- Tuberculosis
- Wheezing

Patient Signature: x_____ Date: _____



SCOTTSDALE PULMONARY & CRITICAL CARE

Recent Medical Care

- Hospitalized Recently: yes no
- If yes:
 - When: _____
 - Where: _____
- Urgent Care Recently: yes no
- If yes:
 - When: _____
 - Where: _____

- If yes:
 - When: _____
 - Where: _____

Vaccinations

- Flu Shot this year:
 - yes no decline to say
 - If yes:
 - When: _____
- Pneumonia Vaccine this year:
 - yes no decline to say
 - If yes, which one:
 - Prevnar 13
 - Pneumovax
- COVID-19:
 - yes no decline to say
 - If yes:
 - Date of Initial dose: _____
 - Date of Booster: _____

Social History

- Tobacco Use: yes no former
 - Type:
 - cigarettes chew cigar
 - pipe
 - Average Per Day: _____
 - Years Used: _____
 - Quit Date: _____
- Alcohol use: yes no former
 - Type:
 - Beer Wine Liquor
 - Drinks Per Week: _____
- Vaping: yes no former
 - If yes, how often: _____
- Recreational Drug Use:
 - yes no former
 - Type: _____
 - How often:
 - daily weekly monthly
- Exercise: yes no
 - If yes:
 - daily weekly monthly

Travel History

- Traveled outside the U.S. recently?
 - yes no

Patient signature: x _____ Date: _____



SCOTTSDALE PULMONARY & CRITICAL CARE

Recent Testing

Please fill in any details of the following tests if they have been done recently:

Test	Where	When
Chest X-Ray		
CT scan (Chest)		
CT scan (Sinus)		
Lab Work		
Pulmonary Function Test		
Echocardiogram		
Sleep Study		

Patient Signature: x _____ Date: _____



SCOTTSDALE PULMONARY & CRITICAL CARE

Medication List

Name: _____ DOB: _____ Date: _____

Pharmacy: _____ Cross Streets: _____

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies

Medication Allergy	Reaction

Patient Signature: x _____