SHASTA CRITICAL CARE
Specialists
2701 Old Eureka Way, Suite 1E
Redding, CA 96001
(530) 232-3000

Dear New Patient,

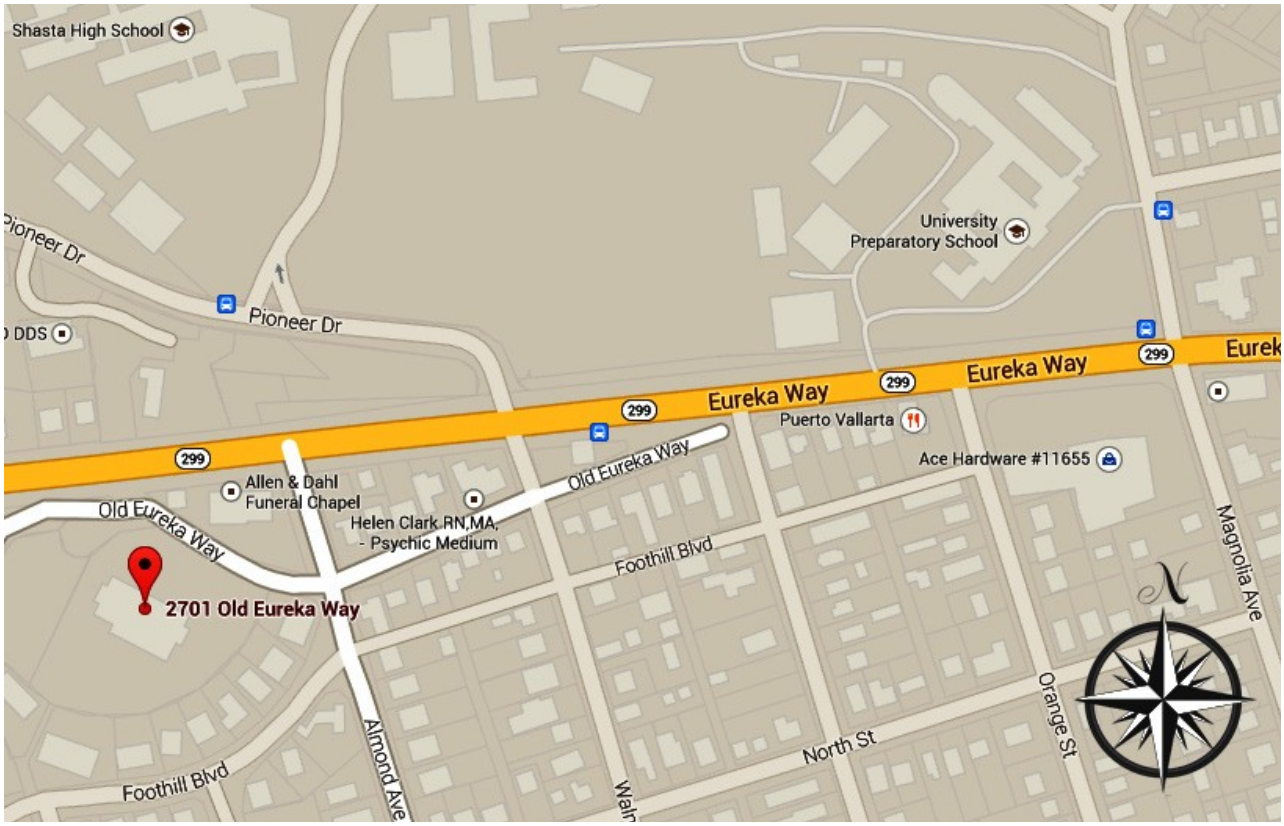
In order to have all your paperwork processed in time for your visit with the physician, please arrive 30 minutes early for your first appointment with your **completed paperwork, insurance cards, photo ID and a completed medication list with dosages**. Our receptionist needs time to process this information for each of our departments. To maintain our schedule, we have found this lead time necessary for welcoming our new patients.

For our nephrology (kidney) patients, please read:

*You will be asked to provide a urine sample upon your arrival, so please make sure you are adequately hydrated. We understand if there is a medical reason for not being able to leave a sample.
*There *may* be a lab order attached to this packet. Please have your labs done no less than 2 weeks prior to your appointment.

For our pulmonary (lung) patients, please read:

*There may be radiology orders attached. Please have your radiology order done within a week of your appointment. You may need to physically bring in a CD or films, so please call our office if you have any questions.



We appreciate your accommodation and hope that your visit to our practice is a pleasant one.
Sincerely,
Shasta Critical Care Specialists

Thank you for choosing our office. In order to serve you properly, we need the following information.
All information will be strictly confidential. ***(PLEASE PRINT)***

Patients Name	Preferred Nickname
Birth Date	Age M/F Social Security #
Marital Status W S M O	Race / Ethnicity
**Email Address	Mailing Address State Zip Code Phone# Cell#
Occupation: Employer:	Employers Address
Person financially responsible for this account: Self Other	If Other, Name: Address State Zip Phone#
Nearest friend or relative not residing with you	Relationship to Patient: Address State Zip Phone#

Cancellation Policy

Patient/PFT Appointments: If you fail to show for your appointment OR cancel your appointment with less than 24 hours notice, you will be charged $25.00

_____**(Initial)** I acknowledge that I have been informed of this policy. I understand that it is my responsibility to pay this fee and that it will be billed directly to me. Payment must be made before my next visit.

Acknowledgement Of Receipt Of Notice Of Privacy Practices
Shasta Critical Care Specialists
Privacy Officer: Office Manager (530) 232-3000

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____**(Initial)** **PATIENT NAME** _____
If not signed by the patient, please indicate relationship

Print Your Name_____ Telephone_____

❑ Parent of Guardian of minor patient ❑ Guardian or conservator of an incompetent patient ❑ Beneficiary or personal representative of deceased patient

RELEASE OF MEDICAL INFORMATION TO:	NAME	RELATIONSHIP
EMERGENCY CONTACT		
FRIEND OR RELATIVE		
FRIEND OR RELATIVE		
FAMILY DOCTOR		
OTHER PHYSICIANS		

Hospital Preference_____ **Pharmacy Preference** _____

- I authorize this office to receive and to release information necessary to the named insurance company (or companies) to expedite insurance payment, and to keep my signature on file for billing purposes. I understand that I am responsible for all charges (including handling fees for late payments), regardless of insurance coverage (unless the physician is contracted with my insurance company including Medicare), for a covered service while my policy is in force. I agree to be responsible for payment when any necessary insurance authorization has not been obtained. I agree to pay for services or supplies that Medicare or any other insurance carrier may deem to be "medically unnecessary" or are otherwise not covered services by my insurance carrier(s).

Signature _____ Date _____

PERSONAL PATIENT INFORMATION

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of Drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

OTHER MEDICAL CONDITIONS

IMMUNIZATIONS – PLEASE ENTER DATES

Tetanus Shot _____ Pneumonia Shot _____

TB Skin Test _____ Flu Shot _____

SURGICAL HISTORY – please list

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:
Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

PSYCHIATRIC
- ❑ Depression
- ❑ Difficulty falling asleep
- ❑ Poor appetite
- ❑ Difficulty staying asleep
- ❑ Food cravings
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Rapid speech
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

OTHER:

SOCIAL HISTORY

ALCOHOL USE
- ❑ Non Drinker
- ❑ Occasional
- ❑ Moderate Consumption
- ❑ Heavy Consumption
- ❑ Recovering Alcoholic
- ❑ Never Drank Alcohol

TOBACCO USE
- ❑ Smoker
- ❑ Occasional
- ❑ Former Smoker
- ❑ Never Smoked

CAFFEINE USE
- ❑ No Caffeine Use
- ❑ Occasional
- ❑ 1 – 2 Servings per day
- ❑ 3 – 4 Servings per day

EXERCISE HABITS
- ❑ Sedentary
- ❑ Moderate Less Than 3X a week
- ❑ Moderate More Than 3X a week
- ❑ Strenuous Less Than 3X a week
- ❑ Strenuous More Than 3X a week

Y N Drug Use
Y N Sun Protection

OFFICE POLICY

Due to the nature of our practice, we must enforce these policies to ensure the highest quality of care for our patients.

Cancellation Policy

We require that all patients give **24 hour notice** prior to missing an appointment. Failure to do so will result in a **$25 no-show fee.**

Rescheduling Policy

Our office will only allow two reschedules, no-shows, or cancellations per year. If you reschedule your appointment more than twice in a year you will need to be re-referred to our office.

Additional Assistance

If you require any additional assistance, such as a wheelchair, you are responsible for providing one for yourself.

Thank you for your compliance,
Shasta Critical Care Medical Specialists

By signing below, I acknowledge that I understand the policies as contained herein.

Print Name:

_____

X_____ Date: _____

THE EPWORTH SLEEPINESS SCALE

NAME: _____ AGE: _____

DATE: _____ MALE FEMALE

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 work out how they would have affected you. Use the following scale to choose the MOST APPROPRIATE for each situation:

Circle one in each row:	0 - No chance of dozing	1 - Slight chance of dozing	2 - Moderate chance of dozing	3 - High chance of dozing
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g., a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Total Score: _____ (Add columns 0-3)				