KEEP FOR YOUR RECORDS

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 at the check-in time with your **completed paperwork, insurance cards, photo ID and a completed medication list with dosages or you will be rescheduled.** 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.

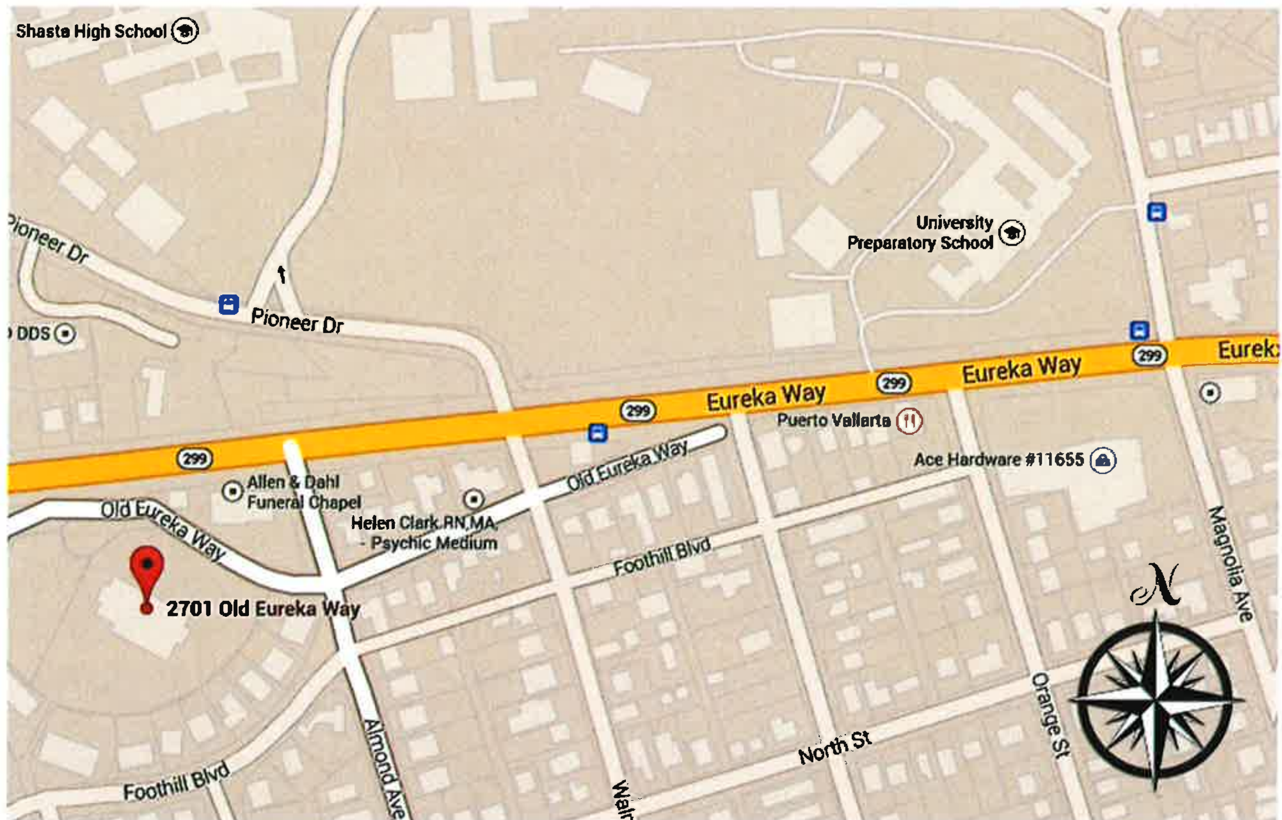
For our nephrology (kidney) patients, please read:

*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 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 City 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

	NAME	RELATIONSHIP/ PHONE NUMBER
EMERGENCY CONTACT		
FAMILY DOCTOR		
PHARMACY		
HOSPITAL PREFERENCE		
DME COMPANY 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 Age (s)	Health & Psychiatric	IF DECEASED 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: ______________________

SHASTA CRITICAL CARE
Specialists

HIPAA Authorization Form for Family Members/Friends

I, ______________________________, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	**Relationship/Phone number**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Health Information to be disclosed (Check all that apply):
[ ] My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
[ ] My complete health record, as above, with the exception of the following information: (check as appropriate):
[ ] Mental health records
[ ] Communicable diseases (including HIV and AIDS)
[ ] Alcohol/drug abuse treatment
[ ] Other (please specify____________________________________
____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):
[ ] All past, present, and future periods, OR
[ ] Date or event: ____________________________________
unless I revoke it. **(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)**

____
Name of the Individual Giving this Authorization

______________________________ ________________
Signature of the Individual Giving this Authorization Date

Sleep Questionnaires (Pre-Treatment)

Name ______________________________ Date ____ / ____ / ____
DD MM YY

You may be asked to complete this questionnaire each time you visit ZMD, as we would like to objectively understand to what extent your sleep apnea and/or snoring is having an impact on your daily activities, emotions, social interactions, and about symptoms that may have resulted. Measuring that prior to starting any treatment, and then again at various stages after starting treatment, is very important. **Please insert the best (Response #) that reflects your response to each Situation described.**

Sleep Apnea Quality of Life Questionnaire (SAQLI)

SITUATIONS	#
1. How much have you had to push yourself to remain alert during a typical day? (e.g. work, school, childcare, housework)	
2. How often have you had to use all your energy to accomplish your most important activity? (e.g. work, school, childcare, housework)	
3. How much difficulty have you had finding the energy to do other activities? (e.g. exercise, relaxing activities)	
4. How much difficulty have you had fighting to stay awake?	
5. How much of a problem has it been to be told that your snoring is irritating?	
6. How much of a problem have frequent conflicts or arguments been?	
7. How often have you looked for excuses for being tired?	
8. How often have you not wanted to do things with your family and/or friends?	
9. How often have you felt depressed, down, or hopeless?	
10. How often have you been impatient?	
11. How much of a problem has it been to cope with everyday issues?	
12. How much of a problem have you had with decreased energy?	
13. How much of a problem have you had with fatigue?	
14. How much of a problem have you had waking up feeling unrefreshed?	

RESPONSE	#
Not at all	**7**
A small amount	**6**
A small to moderate amount	**5**
A moderate amount	**4**
A moderate to large amount	**3**
A large amount	**2**
A very large amount	**1**

TOTAL: ________

Sleepiness Assessment (Epworth Sleepiness Scale)

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? Even if you have not done some of these things recently, try to work out how they would have affected you. **Please insert the best (Response #) that reflects your response to each Situation described.**

SITUATIONS	#
1. Sitting and reading	
2. Watching television	
3. Sitting inactive in a public place (e.g. a theatre or meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after lunch without alcohol	
8. In a car while stopped for a few minutes in traffic	

RESPONSE	#
No chance of dozing	**0**
Slight chance of dozing	**1**
Moderate chance of dozing	**2**
High chance of dozing	**3**

TOTAL: ________