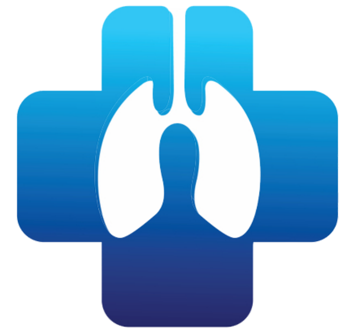
Advanced Respiratory & Sleep Medicine

SKAND Corporation

Pulmonary/Critical Care/Neurocritical Care/Sleep Medicine

105 N. Bascom Ave. Suite. 202 San Jose, CA 95128
ARSMHealth.com
P: (408) 993-1500 F: (408) 993-1521



Sharad Dass, MD, FCCP, FAASM ♦Zerlina Sramek, P.A. ♦Bing Bing Zhang, AGPC, NP

New Patient Registration

Name (Last,First):_______________________________________ DOB: ___________________ Sex: ☐Male ☐Female

Driver's License#: ____________________________________ Issued Date: __________________ State: _________________

Address:____City:____________________ ST: __________ Zip: _____________

Contact#(Primary):____________________________________Email:____

Can we email you your confidential information? ☐ **YES** ☐ **NO**

Preferred Pharmacy: ____ City: _________________________ State:________

***If you require language translation services- our office requires 14 days notice to obtain services from your insurance. This does not guarantee covered service. If services are unable to be covered by insurance, the patient is responsible to find reliable translation during the time of their visit.*

Patient Insurance Information

Primary Insurance Name: ____ Member ID: ___________________________

Member Name: ____ Member Relation: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Name: ____Member ID: ___________________________

Member Name: ____ Member Relation: ☐ Self ☐ Spouse ☐ Child

**I am aware that this private practice does not accept Medi-Cal/Medi-Caid. Therefore, I agree that if I have either of these insurances, the medical services I receive today will be considered under the pretense of a "private pay" patient and payment is to be collected prior to any services rendered.*

Emergency Contact

Contact Name: ____ Relation:_________________________________

Phone:____ Email: ____

Patient Medical History

Please describe the reason for your evaluation today: ____

____

____

Please list all known medication allergies with reaction:

____ Reaction: _______________________________

____ Reaction: _______________________________

____ Reaction: _______________________________

Please list all known NON-med allergies with reaction:
____ Reaction: _____________________________
____ Reaction: _____________________________
Please list All *Other* Known Allergies:
____

Medications: (Please list active/prior/non-active – 3 month history of medications, herbs, supplements)

Medication Name	Dose	Frequency	Reason

Surgical History:

☐ Tonsillectomy/ Adenoids	☐ Bone/ Joint	☐ Biopsies	☐ Gall Bladder
☐ Lung Surgery	☐ Cosmetic	☐ Appendectomy	☐ Thyroidectomy
☐ Heart Surgery / Stents	☐ Dental	☐ Abdominal	☐ Splenectomy
Other unlisted Surgeries:			

Medical History *Please check all that apply*

☐ Allergies	☐ Depression	☐ High Blood Pressure	☐ Sarcoid
☐ Arthritis	☐ Diabetes	☐ Hospitalizations	☐ Sepsis
☐ Asthma	☐ High Cholesterol	☐ Insomnia	☐ Seizures
☐ Alcoholism	☐ Heart Disease	☐ Kidney Disorder	☐ Skin Infections
☐ Anxiety Disorder	☐ Heartburn/Reflux	☐ Lupus	☐ Sleep Apnea
☐ Cancer	☐ Hernia	☐ Liver Problems	☐ Thyroid Disease
☐ COPD	☐ Heartburn/Reflux	☐ Pneumonia	☐ Tuberculosis
		☐ Rheumatoid	

*Other Concerns not listed:
____
____
____

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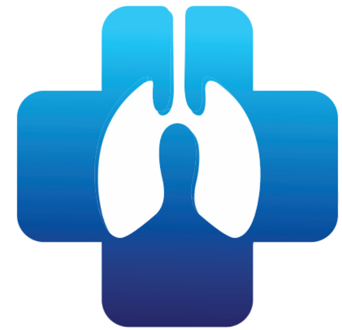

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Immunizations: Please give date of when administered

Pneumovax Date:	Hepatitis A Date:	PPD (TB) Date:
Influenza Date:	Hepatitis B Date:	Covid Vax Date:
TDAP Date:	BCG Date:	Shingles Date:

Review of Systems / Symptoms: *Please check all that apply*

General

- ☐ Weight Loss/Gain ☐ Poor Appetite ☐ Night Sweats ☐ Malaise
- ☐ Fever/Chills ☐ Weakness ☐ Fatigue ☐ Lethargic

Head, Eyes, Ears, Nose, Throat

- ☐ Headache ☐ Tinnitus ☐ Hoarseness ☐ Stuffiness/Earaches
- ☐ Decreased hearing ☐ Nose Bleeds ☐ Tongue Rash ☐ Nasal Discharge
- ☐ Facial Pain ☐ Oral/Lip Ulcers ☐ Visual Changes ☐ Sore Throat
- ☐ Throat itchy/Full ☐ Metallic Taste ☐ Bleeding Gums

Neck

- ☐ Lumps/Mass ☐ Swollen Glands ☐ Limited Movements ☐ Pain/Stiffness

Cardiovascular

- ☐ Chest Pain or Tightness ☐ Palpitations ☐ Swelling in Feet ☐ Faintness
- ☐ Light Headed ☐ Fainting ☐ Cold Feet/Hands ☐ Blood Clots
- ☐ Bluish Fingers/Toes ☐ Hands Tingle ☐ Leg Cramps ☐ Varicose Veins

Respiratory

- ☐ Cough ☐ Wheezing ☐ Coughing Blood
- ☐ Mucus with Cough ☐ Shortness of Breath

Gastrointestinal

- ☐ Change in Bowel Habits ☐ Blood in stool ☐ Dark tarry stools ☐ Constipation
- ☐ Cough w/ Swallow ☐ Vomiting ☐ Nausea ☐ Heartburn
- ☐ Trouble Swallowing

Musculoskeletal

- ☐ Muscle/Joint Pain ☐ Muscle Pain/Stiff ☐ Swelling of joints ☐ Back Pain
- ☐ Pain Limits Activity ☐ Weakness ☐ Knee Pain ☐ Hip Pain

Skin

- ☐ Rashes ☐ Lumps/Bumps ☐ Itching ☐ Dryness
- ☐ Paleness ☐ Jaundice ☐ Erythema/Redness ☐ Burns

Neurologic

☐ Dizziness	☐ Fainting	☐ Seizures	☐ Numbness
☐ Weakness/Paralysis	☐ Tingling	☐ Tremor	☐ Vertigo
☐ Reduced Coordination	☐ Reduced Memory	☐ Reduced Concentration	

Psychiatric

☐ Nervousness	☐ Depressed Mood	☐ Suicidal	☐ Irritable
☐ Panic Attacks	☐ Claustrophobic	☐ Lack of Enthusiasm	

Endocrine

☐ Heat/Cold Intolerance	☐ Excessive Sweating	☐ Frequent Urination	☐ Frequent Thirst

Hematologic

☐ Prior Transfusion	☐ Easy Bleeding	☐ Anemia	☐ Blood Thinners

Allergy/Immunologic

☐ Watery Eyes	☐ Rash	☐ Sneezing	☐ Nasal Drip
☐ Congestion	☐ Allergy Testing	☐ Food Allergy	☐ Dye Allergy
☐ Pollen Allergy			

Sleep

☐ Sleepy While Driving	☐ Snoring	☐ Choking Sensation	☐ Insomnia

Family Medical History: *(parents, grandparents, siblings)*

☐ Allergies	☐ High Blood Pressure	☐ Diabetes	☐ Liver Disorders
☐ Asthma	☐ Heart Disease	☐ Bleeding Problems	☐ Sarcoid
☐ Cancer	☐ COPD	☐ Lung Fibrosis	☐ Sleep Apnea
☐ Lupus	☐ Thyroid Disease	☐ Kidney Disorders	☐ Rheumatoid Arthritis

Other disorders unlisted:

____

Smoking Exposure:

Have you ever smoked? (if yes, please complete smoking history)	☐ **YES** ☐ **NO**
Estimated years of smoking	
Estimated packs per day	
If you quit, when did you quit?	
Have you had second hand smoking exposure?	☐ **Yes** ☐ **NO**

Inhalation Questions:

Have you been exposed to the following for more than 3 months? *Check all that apply*

▢ Asbestos	▢ Brake Pads	▢ Cleaning Supplies	▢ Heavy Metal / Coal Mining
▢ Lead	▢ Explosives / Fire	▢ Warfare Chemicals	▢ Gasoline
▢ Silica	▢ Glass / Fiberglass	▢ Pesticides	▢ Pets (i.e Dogs, Cats, Birds Etc)

Other:

____

Alcohol Use:

Do you drink alcoholic beverages routinely?	☐ **YES** ☐ **NO**
If so, how many drinks per day?	
Has anyone said that you have a drinking problem?	☐ **YES** ☐ **NO**

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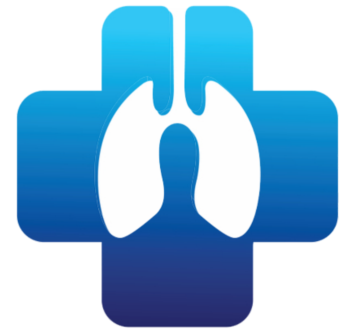

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Did you currently consume any alcoholic drinks?	◻ **YES** ◻ **NO**

Any use of the following in your lifetime? *Check all that apply*

◻ Fen-Phen or weight loss drugs ◻ Amiodarone	◻ Methotrexate ◻ Steroids (ie prednisone/solucortef)	◻ Autoimmune Medications ◻ Cancer Medications

Recreational Drugs: *Check all that apply*

◻Marijuana	◻Cocaine	◻Heroin	◻PCP
◻Ecstasy	◻Anabolic Steroid	Other:	Other:

NOTICE OF PRIVACY PRACTICES

CONFIDENTIALITY OF PATIENT/CLIENT INFORMATION
FROM: ADVANCED RESPIRATORY & SLEEP MEDICINE, SKAND CORPORATION, AND ASSOCIATED MEDICAL STAFF MEMBERS OF 105 N. BASCOM AVE #202, SAN JOSE, CA. 91528.

The Medical Associates will comply with the guidelines of HIPAA, Health Insurance Portability and Accountability Act which became law in 1996. The goals of which are to: protect confidential information of patients (which include but not limited to medical and personal information) and prevent crime.
The information can be used and shared, in a secure manner, for the interest of the patient's health with other businesses associates (BA) which are defined by HIPAA. The BA may utilize the private information for the care of patients directly or indirectly and claims/reimbursements for services. Transferring secure information is done by phone, fax and digitally (email or electronic health record with encryption).
As a client/patient of the Medical Associates,I understand that private and confidential information may be securely shared on behalf of my care. If I declare not to share information with any or a specific Business Associate, then I must provide this in writing. If sharing information conflicts with the ability of the Medical Associates to provide adequate service; then the Medical Associates may refuse service.

AUTHORIZATION & SIGNATURE:
The provided information above is true, and to the best of my knowledge. I have agreed to the office's method of contact via text or email for future appointment reminders and correspondence. My insurance information has been given to the office and I am aware that it may not always guarantee coverage. If medical services are not covered within my insurance, I agree that all medical financial obligations will be my responsibility and paid within 90 days of notice. I understand that it is a requirement to notify the office in advance if there are any medical documents from Valley Radiology, SCVMC, OCH, GSH, and RMC, in order for Advanced Respiratory & Sleep Medicine to obtain medical records of a potential patient. I authorize permission to Advanced Respiratory & Sleep Medicine staff to obtain prior medical documents in order to provide specific and individualistic care for me, as the patient. I authorize the release of this confidential protected health information for treatment, payment, billing, or health care operations for SKAND Corporation, Advanced Respiratory & Sleep Medicine Clinic and associated Health providers. I understand that I may not receive services if I do not authorize my consent. This information to be disclosed is protected by law.

***Appointment /Cancellation Policy:** Patients are given appointment reminders 2 days prior to scheduled appointment via phone,SMS, or email - based on patient preference. If there is no confirmation from the patient, the appointment may be canceled. If a patient fails to confirm/cancel an appointment, an invoice of $50 dollars for No-Show will be applied. Cancellation policy is 24-hours in advance of the patient's scheduled appointment, otherwise fees may apply.

Patient Signature: ____ Date: _______________________

Advanced Respiratory & Sleep Medicine

HIPAA AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. This form authorizes Advanced Respiratory & Sleep Medicine to disclose patient health information to other medical offices/establishments (*ie primary care providers, hospitals, home health etc.*) unless stated otherwise.

I. THE PATIENT.

Patient's Name: ____ DOB: ____________________

II. AUTHORIZATION.

I authorize ADVANCED RESPIRATORY & SLEEP MEDICINE to use or disclose the following: (check one)

☐ – Any/All of my medical-related information.

☐ – My medical information ONLY related to: ____

☐ – My medical-related information from (Date) _________________________ to ________________________

Hereinafter known as the "Medical Records."

III. DISCLOSURE.

The Authorized Party has my authorization to disclose Medical Records to: (*check one*)

☐ – Any party that is approved by the Authorized Party.

☐ – ONLY the following party:

Name: ____

Address: ____

Phone: (____) ____-______ Fax: (____) ____-______

E-Mail: ____

IV. TERMINATION.

This authorization will terminate: (check one)

☐ – Upon sending a written revocation to the Authorization Party.

☐ – On the following date: ________________

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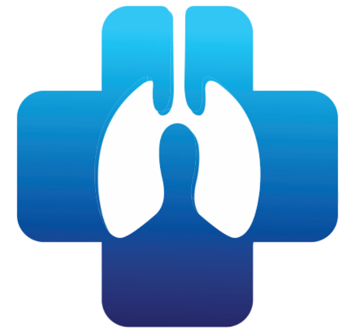

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Print Patient Name: ____

Signature of Patient: ____ Date: ___________

Patient Authorization of Medical Release Form

This form is used by Advanced Respiratory & Sleep Medicine staff to retrieve medical information pertinent to individual patient care. This request is for outside clinics/offices that patients may have previously received care from. Kindly complete the required fields on the form.*

Send to:	Secure Contact:
Advanced Respiratory & Sleep Medicine **105 N. Bascom Ave. Suite. 202** **San Jose, CA 95128**	**P: (408) 993-1500** **F: (408) 993-1521**

Patient Name*: ____ DOB*: _____________________________

Address*:____City*:______________________ State*: _______

Contact*: _____________________________________ Email*: _________________________________

Statement:

I,(*Print Name*) *________________________________ hereby authorize ______________________________ to release my confidential health information to the authorized provider listed below. All medical records are to be released and securely sent to the authorized provider within 10 days of this request.

I understand that I may authorize at any time by submitting a written request to the director of Medical Records. Authorization may be withdrawn except to the extent that action has already been taken in reliance on this authorization. If the authorization was obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy, even if authorization has been withdrawn. I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.

Mental Health Information*	☐ I consent	☐ I do not consent
Alcohol/Drug Abuse Treatment*	☐ I consent	☐ I do not consent
HIV Information*	☐ I consent	☐ I do not consent

Print Patient Name*: ____

Patient Signature*: ____ Date: ___________________