MAB
MEDICAL ASSOCIATES OF BREVARD

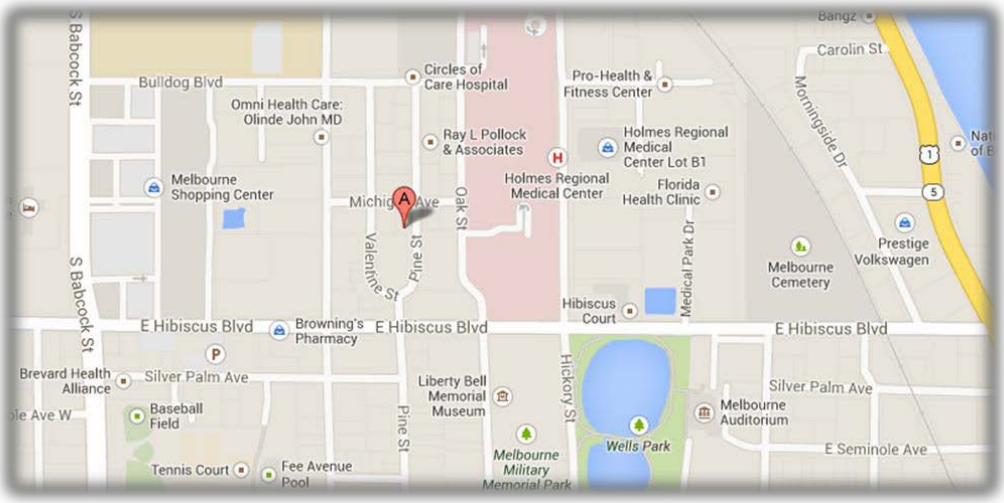
Name:_____DOB:_____

PARVESH K. BANSAL, M.D.
Board Certified Pulmonary, Sleep Medicine, Critical Care, and Laser Surgery

ROBIN TURINETTI, DNP, APRN

1400 Pine Street, Melbourne, FL 32901- PH: (321) 676-6000 - FAX: (321) 676-7000

Welcome To Our Practice



We are located at <u>1400 Pine Street</u>, two blocks west of Holmes Regional Medical Center.

To facilitate a complete evaluation, please do the required items below:

Complete enclosed paperwork, and bring to our office with photo ID and insurance card(s).

Bring a list of all medications that you take on a regular/as needed basis.

If scheduled for a pulmonary consultation, bring your chest X-ray/CT films as directed by referral coordinator. *(Sleep consultations can disregard this unless otherwise informed.)*

Please, refrain from wearing perfumes and colognes, as we care for patients with lung conditions.

Please, do not smoke prior to your appointment.

Your appointment for your pulmonary testing is scheduled for:

Please wear comfortable walking shoes.

_____**at**_____

Your appointment to see Dr. Bansal/Robin Turinetti, APRN is scheduled for:

_____**at**_____

If you have any questions please do not hesitate to call us at 321-676-6000.

New Patient Registration

MEDICAL ASSOCIATES OF BREVARD

Patient Information

Patient Name

_____

First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ◯ MALE ◯ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

◯ Check if same as patient's address

Race

◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian ◯ Black or African American ◯ White
◯ Other Pacific Islander ◯ Prefer not to answer

Ethnicity

◯ Hispanic/Latino ◯ Non-Hispanic/Latino
◯ Prefer not to answer

Preferred Language

◯ English ◯ Spanish ◯ French ◯ Indian (includes Hindu & Tamil) ◯ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

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New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services.
I authorize the payments from my insurance company(s) according to my medical benefits be made payable to ***Medical Associates of Brevard LLC*** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.

Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard LLC. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.

Consent to Obtain External Prescription History

I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.
MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

Community Chart Consent

I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

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OFFICE POLICIES

Please read our office policies carefully, and sign below.

1. If an appointment is not cancelled at least 24 hours in advance, you will be charged a $25 fee. This fee will not be covered by your insurance company.
2. If an appointment has been missed or cancelled, we are unable to fill prescriptions for medications and/or supplies until a new appointment is made.
3. We are unable to schedule a new appointment if a patient has rescheduled or cancelled their appointment three consecutive times.
4. We are unable to schedule a new appointment if a patient has missed their appointment two consecutive times.
5. An office visit is required to receive lab and diagnostic test results. No results will be given by phone.
6. All copayments, coinsurances, deductibles, and balances are due at the time of service.

By signing below, I acknowledge that I have read all of the above office policies. I understand that failure to comply with these policies will result in being discharged from this practice.

*SIGNED:*_____*DATE:*_____

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PERSONAL MEDICAL HISTORY

Reason for Visit Today: _____

Review of Symptoms (CURRENT symptoms only):

General

- Fever ❑
- Fatigue ❑
- Night Sweats ❑
- Weight Gain ❑
- Weight Loss ❑

Skin

- Severe Bruising ❑
- Hives ❑

HEENT

- Glaucoma ❑
- Nasal Congestion ❑
- Runny nose ❑
- Seasonal Allergies ❑
- Sinus Pain ❑
- Snoring ❑

Neck

- Neck Mass ❑
- Neck Swelling ❑

Respiratory

- Bloody phlegm ❑
- Phlegm: color_____ ❑
- Difficulty breathing ❑
  - At rest?
  - With Activity?
- Wheezing ❑
- Cough ❑

Cardiovascular

- Chest Pain ❑
- Edema/ leg swelling ❑
- Palpitations ❑
- Irregular Heart Beat ❑

Gastrointestinal

- Change in Bowel Habits ❑
- Difficulty Swallowing ❑
- Heartburn ❑
- Black or Bloody Stools ❑

Musculoskeletal

- Backache ❑
- Leg Cramps ❑
- Leg pain when walking ❑

Neurological

- Attention Deficit ❑
- Decreased Memory ❑
- Difficulty Swallowing ❑

Psychiatric

- Anxiety ❑
- Depression ❑
- Insomnia ❑

Allergies and Reaction (include environmental allergies, medication and/or food allergies): _____

_____

Immunizations: COVID ☐ Date: ____ Flu ☐ Date: _____ Pneumonia ☐ Date: _____

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Smoking:

Do you smoke? Yes ❑ No ❑ Have you ever smoked? Yes ❑ No ❑

Which Product(s): Cigarettes Marijuana Cigars Vape # of packs per day did smoke at most? ____

What year or age did you start smoking: _____ What year or age did you quit smoking? _____

Any significant exposure to second hand smoke? Yes ❑ No ❑

Alcohol Use:

Do you drink alcohol? Yes ❑ No ❑ previous use ❑

Type of Alcohol:_____ # of drinks per day_____or per week_____

Drug Use:

Do you use illicit drugs? Yes ❑ No ❑ previous use ❑

Type of illicit drugs used:_____ Frequency: _____

Pets:

Do you have any pets? YES/NO If so what kind/how many? _____

Immediate Family History:

Please check if any immediate blood relatives have had any of the following and note the relationship:

COPD/Emphysema	❑_____	High Blood Pressure	❑_____
Asthma	❑_____	Heart Disease	❑_____
Alpha One Deficiency	❑_____	Stroke	❑_____
Tuberculosis	❑_____	Diabetes	❑_____
Lung Cancer	❑_____	Any Sleep Disorder	❑_____

Is your mother Living ❑ Deceased ❑ Cause of Death? _____

Is your father Living ❑ Deceased ❑ Cause of Death? _____

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Past Medical History (Please check any that apply):

COPD/Emphysema	❑	Sleep Apnea	❑
Asthma	❑	Restless Legs	❑
Autoimmune disorder_____	❑	Lung Cancer	❑
Tuberculosis	❑	Coronary Disease	❑
Pneumonia	❑	Atrial Fibrillation	❑
Respiratory Failure	❑	Cardiomyopathy	❑
Pulmonary Embolism	❑	Stroke	❑
DVT	❑	High Blood Pressure	❑
Pleural Effusion	❑	Diabetes	❑
Bronchitis – Recurrent	❑	Other Cancer	❑
Congestive Heart Failure	❑	Hypothyroidism	❑

*__Any other diagnosis you have that is not mentioned above_______

Prior Testing:

❑Sleep test: date_____ ❑Chest X-ray: date_____ ❑CT Chest: date_____ ❑PET Scan: date_____

Surgical History

Lung Surgery	Yes	❑	No	❑	If yes, when: _____
Heart Surgery	Yes	❑	No	❑	If yes, when: _____
Tonsillectomy	Yes	❑	No	❑	If yes, when: _____
Sleep Apnea Surgery	Yes	❑	No	❑	If yes, when: _____

Other Major Hospitalizations or Surgeries: _____

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PULMONARY QUESTIONNAIRE

Cough:

Do you usually cough first thing in the morning?	Yes ❑	No ❑
Do you usually cough after going to bed at night	Yes ❑	No ❑
Do you usually cough after eating or drinking?	Yes ❑	No ❑
Do you cough every day for > 6 months?	Yes ❑	No ❑
How long have you had this cough? ____# of Days	____# of Weeks	____# of Months
Do you bring up phlegm or sputum when you cough?	Yes ❑	No ❑
Have you ever coughed up blood?	Yes ❑	No ❑
Do you wake at night with an acid sour taste in your mouth?	Yes ❑	No ❑
Do you wake up with a sore throat in the morning?	Yes ❑	No ❑
Do you experience hoarseness when talking?	Yes ❑	No ❑
Do you experience burning chest pain?	Yes ❑	No ❑

Asthma/COPD/Bronchitis:

Have you ever noticed whistling or wheezing in your chest? Yes❑ No❑

If yes, how frequent? Daily ❑ Weekly ❑ Monthly ❑ With Colds Only ❑

Is your wheezing more common during a particular season? Yes ❑ No ❑ Which Season(s)? _____

Is your wheezing related to any of the following? (Check all that apply)

House Dust ❑ Animals ❑ Deep Breaths ❑ Cough ❑ Meals ❑

Have you ever gone to the Emergency Room for Asthma?	Yes ❑	No ❑	How many times? _____
Have you ever hospitalized for Asthma?	Yes ❑	No ❑	How many times? _____
Have you ever gone to the Emergency Room for COPD?	Yes ❑	No ❑	How many times? _____
Have you ever hospitalized for COPD?	Yes ❑	No ❑	How many times? _____

How often do you need antibiotics? _____ How often do you need steroids/prednisone? _____

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Medications

Please list all medications (**Prescribed or Over the Counter)** that you are currently taking. You may attach a list.

Name of Medication?	Dose / Strength?	Frequency?	Who Prescribes This To You?

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SLEEP QUESTIONNAIRE

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can.

Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past:

_____

_____

SLEEP HISTORY

Do you experience any of the following at night?

Snoring❑ Insomnia ❑Waking to urinate ❑Leg Cramps ❑ Stopping Breathing ❑ Excessive Daytime Sleepiness ❑

Have you ever been diagnosed with ANY sleep disorder? _____

What time do you go to sleep on workdays? _____ On non-workdays? _____

How long does it take you to fall asleep? _____

What time do you wake up on workdays?_____ On non-workdays? _____

How many times do you wake up during the night? _____

Do you have feelings of depression/anxiety?	Yes	❑	No	❑
Do you have feelings of anxiety or racing thought?	Yes	❑	No	❑
Do you have hallucinations upon falling asleep or upon waking?	Yes	❑	No	❑
Do you have crawling sensations in your legs?	Yes	❑	No	❑
Do you work split shifts or variable shifts?	Yes	❑	No	❑
Do you usually drink caffeine within two hours of going to bed?	Yes	❑	No	❑
Awaken from sleep short of breath or gasping for air	Yes	❑	No	❑
Experience crawling and aching feelings in your legs	Yes	❑	No	❑
Have you been told you snore at night?	Yes	❑	No	❑
Sweat excessively at night	Yes	❑	No	❑
Notice your heart pounding or beating irregularly during the night	Yes	❑	No	❑
Fall asleep during the day	Yes	❑	No	❑
Fall asleep involuntarily or while driving	Yes	❑	No	❑
Fall asleep or lose muscle tone when laughing or crying	Yes	❑	No	❑
Feel unable to move (paralyzed) when waking or falling asleep	Yes	❑	No	❑
Experience vivid dreamlike scenes upon awakening or falling asleep	Yes	❑	No	❑
Remember your dreams	Yes	❑	No	❑
Do any of your family members have sleep apnea?	Yes	❑	No	❑