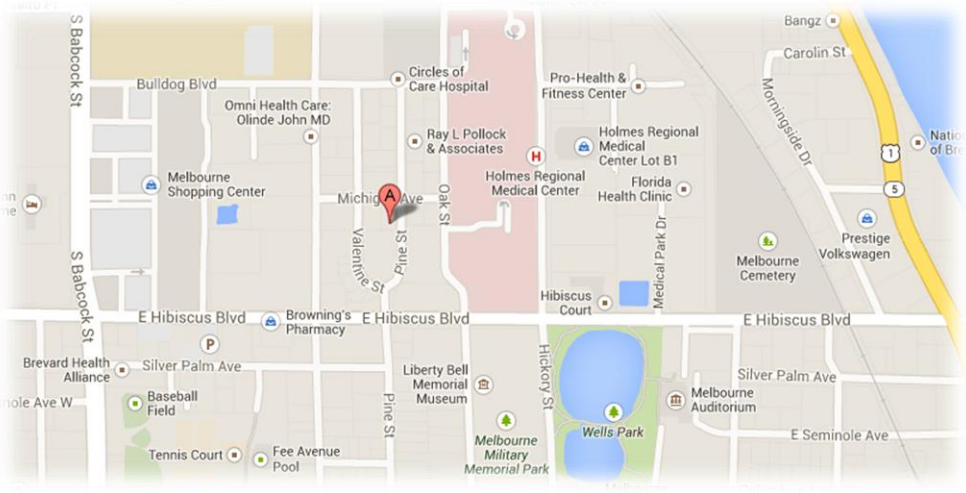
MAB
MEDICAL ASSOCIATES OF BREVARD

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

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 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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NAME:_____ **DOB:**_____

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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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:_____ Sex:_____ DOB:_____
(LAST) (FIRST) (MI)

PERSONAL HISTORY AND HEALTH HABITS:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Occupation: _____

Education: _____years elementary _____years high school _____years college

Place of birth: _____ What year you moved to FL: _____

Pets in your home? YES or NO Type of pets and quantity: _____

Have you ever been exposed to any occupational hazards? (Ex. Asbestos, dust, chemicals)_____

If yes, please explain. _____

Have you ever used tobacco products? YES or NO. If yes, cigarettes, cigars, pipe, or chewing tobacco?

Are you currently smoking? YES or NO How much tobacco per day do/did you smoke per day? _____

At what age did you start smoking? _____ ___ At what age did you quit smoking? _____

Do you drink alcohol? _____ If yes, how many *drinks_____ per day/week/month/year?

***One drink equals 12 ounce bottle of beer, 5 ounce glass of wine, or 1.5 shot of distilled spirits.

Do you use any recreational drugs? _____ If yes, what type? _____

Place an (X) next to the following tests you have had, and if you can note the year you last had them.

_____Chest X-ray _____PET/CT _____Chest CT

_____Sleep Study _____T.B. Skin Test _____T.B. Positive/Negative

_____Flu Vaccine _____Pneumonia Vaccine

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FAMILY HISTORY

	Age	List any illnesses	If deceased cause of death	Age deceased
Mother				
Father				
Siblings How many?____				
Children How many?____				

ALLERGIES

Drug	Reaction

OPERATIONS/HOSPITALIZATIONS

Surgery/Hospitalizations	Date/Year (approximate)

MEDICATIONS

Drug Name	Strength	Frequency Taken

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NAME:_____ **DOB:**_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

☐ Weight loss (without trying)	☐ Wheezing	☐ Difficulty swallowing
☐ Weight gain	☐ Cough, dry	☐ Heartburn/Reflux
☐ Night sweats	☐ Cough with phlegm	☐ Vomiting
☐ Fever	☐ Shortness of breath w/ activity	☐ Diarrhea
☐ Chills	☐ Blood in sputum	☐ Frequent urination at night
☐ Loss of appetite	☐ Difficulty falling asleep	☐ Blood in urine
☐ Loss of consciousness	☐ Difficulty staying asleep	☐ Painful urination
☐ Tremors	☐ Daytime fatigue/sleepiness	☐ Joint pain
☐ Tingling	☐ Snoring	☐ Generalized muscle aches
☐ Double vision	☐ Chest pain	☐ Kidney disease
☐ Sinus pain	☐ Chest tightness	☐ Anxiety
☐ Sinus Drainage	☐ Palpitation	☐ Mood swings
☐ Hoarseness	☐ Swelling of ankles/feet	☐ Panic attacks
☐ Nasal polyps	☐ Swelling in neck/underarms	☐ Depression

Any other important symptoms? _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

☐ Allergy/Hay fever	☐ Tuberculosis	☐ Seizure
☐ Asthma	☐ Heart Disease	☐ Cancer_____
☐ COPD	☐ High blood pressure	☐ Diabetes
☐ Bronchitis	☐ High Cholesterol	☐ Acid reflux
☐ Pneumonia	☐ Heart attack	☐ Sleep Apnea
☐ Pleurisy	☐ Stroke/TIA	☐ Insomnia