Patient Information & Authorization of Treatment

Patient Information

Patient Name:_____ Birth Date:___/___/___ Today's Date: ___/___/___
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____ SSN:_____-_____-_____
Gender: ☐ Male ☐ Female Language:_____ Race:_____
Ethnicity:_____
Address:_____
City:_____ State:_____ Zip:_____ Marital Status: ☐S ☐M ☐W ☐D
Spouse/Guardian:_____ SSN:_____-_____-_____ Phone:_____
Emergency Contact:_____ Relationship:_____ Phone:_____

Pharmacy Information

Pharmacy Name:_____ Phone:_____ Fax:_____
Address:_____City:_____ State:_____ Zip:_____

Referring or Primary Care Physician

Physician Name:_____ Phone:_____ Fax:_____
Address:_____City:_____ State:_____ Zip:_____

Patient Permission to Communicate Medical Information

The patient and/or authorized representative of the patient whose signature is affixed below does herby permit and does not object to the communication of medical information related to my care and condition to the following two individuals.

Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

Signature:_____ Date:_____

Patient Portal

Would you like to be web enabled: ☐ Yes ☐ No

Signature:_____ Date:_____

Authorization to Release Information

I hereby authorize my treating physician to release any information acquired in the course of my examination or treatment.

Signature:_____ Date:_____

Acknowledgment of Financial Obligation

I understand that I am personally responsible for the cost of the services rendered.

Signature:_____ Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of Integra Health, P.C. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices of Integra Health, P.C.

Signature:_____ Date:_____

FOR OFFICE USE ONLY

Insurance Cards Copied: ☐ YES ☐NO Self Pay: ☐ YES ☐NO

Good faith efforts: The patient presented to the office on _____/_____/_____ and was provided with a copy of Integra Health, P.C.'s Notices of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign
☐ Patient was unable to sign
☐ The patient had a medical emergency and an attempt to obtain the acknowledgment will be made at next available opportunity
☐ Other: _____

Signature:_____ Date:_____

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	**CHANCE OF DOZING**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE _____

Patient Name:_____ Patient DOB:_____ Date: _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35 kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

Name_____

Height___**Weight** _____

Age___**Male / Female** _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Phone: (951) 200-5154
Fax: (951) 302-0800

Patient Name	Patient Date of Birth

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

FROM:

_____
(Disclosing physician or provider)

_____
(Street Address)

_____
(City, State, Zip Code)

TO: **Integra Health, PC**

_____
(Receiving physician or provider)
44605 Avenida de Missiones, Suite 206

_____
(Street Address)

Temecula, CA 92592

_____
(City, State, Zip Code)

Release records and information regarding:

_____
(Patient's Name)

_____ _____ _____
(Date of Birth) ***(Social Security #)*** ***(Telephone Number)***

_____
(Address, City, State, Zip Code)

DURATION: This Authorization shall become effective immediately and shall remain in effect through _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the
Requestor or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

AUTHORIZATION TO RELEASE MEDICAL RECORDS (continued)

SPECIFY RECORDS: ☐ **Medical Information** ☐ **X-Ray/Other Imaging**

☐ **Psychiatric**

_____ _____

Signature ***Date***

☐ **Drug/Alcohol**

_____ _____

Signature ***Date***

Date

☐ **Other (specify)** _____

_____ _____

Signature ***Date***

Paper _____ **CD/Other Portable Storage** _____

REQUESTED RECORDS TO BE PROVIDED VIA:

I request that the health information released pursuant to this authorization be used for the following purposes only: _____

_____

_____ _____

Patient/Guardian Signature ***Date***

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization and the copy is for me to keep.

_____ _____

Patient/Guardian Signature ***Date***

_____

Relationship to Patient (if signed by other than Patient)

YOUR RECORDS FOR **2 YEARS** IS ALL THAT WILL BE COPIED UNLESS OTHERWISE REQUESTED. THERE MAY BE A CHARGE FOR RECORDS OLDER THAN 2 YEARS .

PLEASE ALLOW 10 WORKING DAYS TO PROCESS REQUEST.