SLEEP CENTER OF YUMA
ASHVIN K. SHAH, M.D., P.C.
MARVIN LESSER, M.D.
2110 W. 24th Street
Yuma, AZ 85364
Pulmonary Office: (928) 344-1891 • Sleep Center: (928) 726-7106 • Fax: (928) 726-6306

PATIENT INFORMATION **Date:**_____

Patient's Last Name: _____ **First:** _____ **Middle:**_____
SSN #: ___-___-_____ **Date of Birth:** _____ **Age:** _____ **Sex: M F**
Marital Status (please circle one): Single Married Divorced Separated Widowed
Race:_____ **Ethnicity:**_____ **Preferred Language:**_____
Mother's Maiden Name:_____
Address: _____ **City:** _____ **State:**_____ **Zip:**_____
2nd Address: _____ **City:** _____ **State:** _____ **Zip:**_____
Home Phone #: _____ **Cell Phone #:** _____ **E-mail:**_____
Primary Care Provider: _____ **Preferred Pharmacy:**_____
Occupation: _____ **Employer:** _____
Please choose one: Full-time Part-time Temporary
Employer Address: _____
City: _____ **State:** _____ **Zip:** _____ **Employer Phone Number:** _____
Emergency Contact Name: _____**Relationship to Patient:** _____
Emergency Contact Phone Number:_____
How did you hear about us ? Please circle one. Dr._____ Insurance Plan Hospital Relative Friend Close to home/work Yellow Pages Other
Other family members seen here:_____

INSURANCE INFORMATION

Is this patient covered by insurance? Y N
If not, please indicate person responsible for payment.
Name: _____ **Address:**_____
City: _____ **State:** _____ **Zip:** _____ **Phone #:**_____
Birth date:_____ **Is this person a patient here? Y N**
Occupation: _____**Employer:**_____
Employer Address: _____**Employer Phone :**_____

Name of Primary Insurance: _____ **Subscriber's Name:**_____
Subscriber's Birth Date: _____**Subscriber's SSN#:**_____ **Relationship to Patient:**_____
ID Number: _____ **Group Number:**_____

Name of Secondary Insurance: _____ **Subscriber's Name:**_____
Subscriber's Birth Date: _____**Subscriber's SSN#:**_____ **Relationship to Patient:**_____
ID Number: _____ **Group Number:**_____

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PLEASE READ! YOUR SIGNATURE IS REQUIRED.

CONSENT FOR MEDICAL RELEASE:
The above information is true to the best of my knowledge. I hereby authorize Dr. Shah/Dr. Lesser to release information required in the course of my examination or treatment (including insurance companies, durable equipment providers, physician's offices, etc.).

_____ _____
Patient/Guardian Signature **Date**

CONSENT FOR MEDICAL TREATMENT:
Knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examinations.

_____ _____
Patient/Guardian Signature **Date**

AUTHORIZATION TO PAY:
I hereby authorize payment directly to Dr. Shah/Dr. Lesser for medical benefits, if any, and otherwise payable to me for services. I understand that I am financially responsible for charges not covered by my insurance. I authorize the use of this signature on all of my insurance claims.

_____ _____
Patient/Guardian Signature **Date**

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INSTRUCTIONS: PLEASE MARK AND ANSWER EVERY QUESTION TO THE BEST OF YOUR RECOLLECTION.

NAME: _____ **DATE OF BIRTH:** _____

LIST ALL MEDICAL CONDITIONS (past and present):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

LIST ALL HOSPITALIZATIONS AND SURGERIES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

CURRENT MEDICATIONS:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES: _____

PERSONAL & SOCIAL HISTORY:

Occupation: _____
Marital Status: _____
Tobacco use: Never ____ Former ____ Year quit _____
How much _____ Current smoker _____ How much _____
Alcohol use: Never _____ Former _____ Current _____
Nearly daily _____ How much _____
Recreational Drug Use: Never _____ Current _____
Former _____ Year quit _____
Have you ever used intravenous drugs? _____

FAMILY HISTORY:

Present age (or age at death):
Father: _____
Mother: _____
Brothers/Sisters: _____
Children: _____
Did any relative ever have asthma, lung cancer, sleep apnea, emphysema, tuberculosis or a heart attack?

High Blood Pressure:	**YES**	**NO**
Cancer:	**YES**	**NO**
Heart Attack:	**YES**	**NO**
Stroke:	**YES**	**NO**
CHF:	**YES**	**NO**
Ulcers/Reflux:	**YES**	**NO**

Surgeries:

Tonsillectomy:	**YES**	**NO**
Appendectomy:	**YES**	**NO**
Gallbladder:	**YES**	**NO**
Lungs:	**YES**	**NO**
Coronary artery bypass:	**YES**	**NO**
Hysterectomy:	**YES**	**NO**

Review of Systems (Check all that apply.)

1. **Digestive:** Heartburn _____ Vomiting _____ Blood in bowel movement _____ Jaundice _____ Constipation _____ Diarrhea _____ Difficulty swallowing _____ Abdominal pain _____ Change in bowel habits _____
2. **Constitutional:** Weight loss ____ Fever ___ Fatigue ____
3. **Ear/Nose/Throat/Eyes:** Cataracts _____ Hoarseness of voice _____ Sore throat _____
4. **Cardiovascular:** Chest pain _____ Palpitations ____ Shortness of breath upon exertion _____
5. **Respiratory:** Cough _____ Shortness of breath _____ Wheezing _____
6. **Genitourinary:** Problems passing urine ____ Blood in urine _____ (Females: Date of last menstrual period) _____ Burning with urination _____ History of sexually transmitted diseases _____
7. **Hematological:** Blood transfusions _____ Easy bruising or bleeding _____
8. **Musculoskeletal:** Joint pains _____ Swelling of joints ____ Muscle aches _____
9. **Neurological:** Headache ____ Seizures _____ Loss of consciousness _____
10. **Psychological:** Emotional stress _____ Anxiety _____ Depression _____ Suicidal thoughts/attempts _____
11. **Dermatological:** Rash ____ Skin cancer _____
12. **Endocrine:** Thyroid disorder _____ Diabetes _____
13. **Sleep:** Snoring _____ Stopped breathing _____ Excessive daytime sleepiness _____

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FINANCIAL POLICY

We would like to take this opportunity to welcome you and thank you for choosing us for health care. The following is the Financial Policy for Dr. Ashvin K. Shah and Dr. Marvin Lesser. Please read and sign the Financial Policy and complete the Patient Registration form prior to seeing the doctor. If you would like a copy of the Financial Policy, please inform the receptionist. **Please be advised if you lapse in treatment from our facility for a six year period of time, your medical records will be destroyed thereafter.**

Regarding Insurance/Office Visits/Hospital Admission:
Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We will bill non-contracted insurance companies as a courtesy for your office visits. If we are contracted providers with your insurance companies, co-pays and deductibles are due at the time of service. **Referrals required by insurance companies must be presented to the receptionist; if a referral is not obtained at the time of service, the appointment will be rescheduled. Obtaining the referral is the patient's responsibility.** Services obtained in the hospital will be billed to your insurance company; however, you are responsible for all non-covered services. We will accept benefits, however, deductibles and cost shares remain your responsibility. The physician has limited knowledge as to your charges. All questions or concerns regarding your charges must be directed to the billing department or the office manager. Full payment is due at time of services for all non-contracted insurance companies. Our forms of payment are: cash, checks, Visa and Mastercard.

Usual and Customary Charges:
Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary charges.

Supplemental Insurance:
Medicare patients: We will bill all secondary payers; however, if your secondary insurance does not pay within 30 days from the Medicare payment, you will be responsible for payment and collecting from your secondary insurance. Secondary insurances will be billed one time only, if the secondary insurance does not pay within 30 days of original billing, you will be billed for the balance.

Bad Debt/Collection: If your account is turned over to collection agency, all future visits will be charged on a cash basis.

If you have any questions about the above information, or any uncertainty regarding insurance, please do not hesitate to ask us. We are here to help you!

SIGNATURE (Patient or Responsible Party): _____ DATE: _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

- ☐ Patient signed and accepted notice.
- ☐ Patient refused to sign notice.
- ☐ Patient unable to sign notice; however, spouse signed.
- ☐ Patient underage, notice signed by parent or guardian.

SIGNATURE (PATIENT OR GUARDIAN):_____ **DATE:**_____