Salem Pulmonary Associates, PC & Sleep Center

STEVEN MARVEL MD
MARTIN C JOHNSON MD
KAMRAN FIROOZI MD
FAYEZ BADER MD
NIMESHKUMAR MEHTA MD
KAVAN RAMACHANDRAN MD
KISHAN RAMACHANDRAN MD
WENN JEAN NG MD
KOVID TRIVEDI MD MD

Dear Patient,

Your New Patient Evaluation has been scheduled for: _____

We would like to welcome you as a new patient and thank you for choosing Salem Pulmonary Associates, P.C. and Sleep Center for your health care needs. We are a specialty medical practice providing care for patients with pulmonary and sleep related disorders. It is our goal to provide you with the highest level of care and wish to make your appointments here an informative and rewarding experience.

We encourage you to make a list of any questions you may have. During your initial evaluation we will review your complete medical history and ask questions regarding your overall health and history of symptoms, perform a thorough physical exam that may include obtaining chest X-rays and/ or performing pulmonary function (breathing) tests. Learning as much as we can about you, helps us to provide a more personalized diagnosis and treatment plan for you.

To assist us in making your first visit more efficient, please fill out each of the forms attached. We also ask that you bring the following to your appointment:

1. *Current medication/allergy list*
2. *Picture I.D. (State issued driver's license, state issued I.D., military I.D.)*
3. *Current Insurance card*

Please arrive 30 minutes prior to your scheduled appointment time with your completed forms and other requested information.
Failure to complete paperwork prior to your appointment may result in rescheduling.

Please feel free contact us at (503)588-3945 if you have any questions.

Thank You,

Salem Pulmonary Associates, P.C. and Sleep Center

SALEM PULMONARY ASSOCIATES, PC AND SLEEP CENTER
801 MISSION ST SE
SALEM, OR 97302-6222
503-588-3945 503-588-0256 FAX

PATIENT INFORMATION

Name: _____ DOB: _____
Last First M.I.

Home Address: _____
Street City/State Zip

Home Phone: (____)_____ Work: (____)_____ Cell: (____)_____

May we leave a message at your home? YES NO At your place of employment? YES NO

Email Address: _____ SSN: _____

Marital Status: Single Married Divorced Separated Widowed

Race: _____ Language: _____ Ethnicity: _____

Employer: _____ Occupation: _____

Employer Address: _____
Street City/State Zip

Primary Care Physician: _____ Referring Physician: _____

SPOUSE/PARENT INFORMATION/OTHER RESPONSIBLE PERSON

Name: _____ DOB:_____
Last First M.I. Relationship: _____

Home Address: _____
Street City/State Zip
Home Phone: (____)_____ Work: (____)_____ Cell:(____)_____

Email Address: _____ SSN: _____

METHOD OF PAYMENT: CASH CHECK CREDIT CARD INSURANCE OTHER

Primary Insurance Co: _____ Policy #: _____ Group #: _____

Secondary Insurance Co: _____ Policy #: _____ Group #: _____

Is this office visit due to a work injury?: _____

Signature: _____ **Date**: _____

801 MISSION ST SE
SALEM, OR 97302-6222
503-588-3945 503-588-0256 FAX

Form 2A-1

Disclosure of PHI and Treatment, Payment, and Health Care Operations

Under the HIPPA Privacy Rule, Salem Pulmonary Associates, PC may disclose protected health information (PHI) for treatment, payment, or health care operations without permission from an individual under the following circumstances:

1. **For our treatment, payment, or health care operations (TPO)**
2. **For treatment activities of another health care provider**
3. **For the payment activities of another covered entity or health care provider, as long as the recipient of the PHI is that covered entity or health care provider**
4. **For purposes of health care operations, between covered entities participation in an organized health care arrangement (OHCA)**

The terms, treatment, payment, and health care operations, as well as health care provider and covered entity have specific meanings that must be understood before disclosure. Please read Form 2B-1 (Spa Office) for more information regarding your rights. Please see our Privacy Officer for an explanation of these terms.

I understand that during the course of normal business, Salem Pulmonary Associates, P.C. and Sleep Center may need to electronically transmit (fax) my medical records. I hereby authorize such transmission and absolve Salem Pulmonary Associates, P.C. and Sleep Center, its physicians, and its employees of any liability relating to such transmission of records.

If you have any questions regarding the permissibility of the disclosure or use of the information, please contact our Privacy Officer: Mark Harrison (503)588-3945.

ACCEPT: _____ **DO NOT ACCEPT: _____**

_____
Signature of Individual Authorizing Release of Information

_____
Printed Name

_____/_____/_____
Date of Birth

_____
Date

I hereby authorize the use and/or disclosure on my PHI with the person or person's listed below: I give permission for them to receive and have access to my PHI. I understand that this authorization is voluntary and is not part of my treatment.

Name: _____ **Relationship: _____**

Name: _____ **Relationship: _____**

Name: _____ **Relationship: _____**

- **You may revoke this authorization at any time by providing written notice to:**
- **Salem Pulmonary Associates, P.C. and Sleep Center 801 Mission St SE, Salem, Or 97302-6222.**
- **Your revocation will not affect any actions already taken in reliance on this authorization.**
- **You are entitled to receive a copy of this authorization upon request**

SALEM PULMONARY ASSOCIATES, PC AND SLEEP CENTER
801 MISSION ST SE
SALEM, OR 97302-6222
503-588-3945 503-588-0256 FAX

Salem Pulmonary Associates, P.C. and Sleep Centers goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy, allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions please do not hesitate to ask a member of our staff.

1. Upon arrival, please present your current insurance card(s) at every visit. Please inform us of any changes in your personal information.
2. It is your responsibility to understand your insurance plan and if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure and what services are covered. Please be aware that if you choose to be seen before you have received a valid authorization your insurance may not pay for the visit. The Business Office cannot guarantee payment for services or coverage of services from your health plan. Patients are ultimately responsible for understanding their coverage limitation and benefits.
3. According to your insurance plan, you are responsible for any and all co-payments, deductible and co-insurances at time of service. Co-payments are the amount your policy requires us to collect with each visit. Please be prepared to pay at the time of your visit. The co-insurance is the percentage of the bill that is your responsibility according to the contract with your insurance company. The deductible is the total amount your policy requires you to pay before they pay a claim on your behalf. We will be collecting a portion or all of your owing co-insurance or deductible at the time of your office visit. We accept cash, check, Visa, Mastercard and American Express.
4. Patients without insurance or seeing a provider out of network will be required to make a deposit at the time of the visit at the following rates: New patient office visit- $100 deposit, Established patient office visit-$100 deposit, Sleep Study procedures-$100 deposit.
5. Patient balances are billed immediately upon receipt of your insurance plans explanation of benefits. Your remittance is due 10 business days from receipt of your bill.
6. If previous arrangements have not been made with our finance office, any account balance over 90 days will be turned over to a collection agency.
7. A $25 fee will be assessed for all appointments cancelled without a 24 hr notice.
8. A $35 fee will be assesses for not showing up for your scheduled appointments.
9. **Patients who accumulate a total of 3 No Show/Same Day cancellations within a 12 month period, will automatically be TERMINATED from SPA as a patient. Exceptions will be made dependent on circumstances.**
10. **If you have not been seen in over one (1) year, Salem Pulmonary Associates, P.C. and Sleep Center WILL NOT REFILL ANY PRESCRIPTIONS UNTIL YOU ARE SEEN.**

I acknowledge that I am financially responsible for all charges whether or not they are covered by my insurance. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself and that my doctor and/or his staff are not the administrators of the policy. I authorize payment of my medical benefits to Salem Pulmonary Associates, P.C. and Sleep Center and my doctor for medical services rendered. A photocopy of the signature is as valid as the original.
If it becomes necessary to effect collections for any amount owed on this or subsequent visits, the undersigned agrees to pay for all the costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. Any check returned to Salem Pulmonary Associates, P.C. and Sleep Center due to non-sufficient funds will be charged a fee of $25.00.
I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

_____ _____
Patient Name (Please Print) Date

_____
Patient, Parent or Guardian Signature

Salem Pulmonary Associates, PC & Sleep Center

Pulmonary Consultation – Patient History Form

Welcome to Salem Pulmonary Associates. In order to insure your best care, it is important that you take the time to complete this pulmonary patient medical history questionnaire thoroughly.

Name: _____ Age: _____ Date of Birth: ___/____/_____

Date: ___/____/____ Referring Physician: _____ Primary Care Physician:_____

Why are you seeing a lung doctor?_____

_____

How long have you had this problem? _____

Respiratory Assessment Questionnaire: (Please circle Y for Yes or N for No)

Y/N Unable to catch your breath at rest
Y/N Wheezing
Y/N Frequent sputum production
Y/N Chest pain or pressure
Y/N Night sweats
Y/N Excessive sleepiness or fatigue
Y/N Previous abnormal chest x-ray
Y/N Collapsed lung (Pneumothorax)
Y/N Shortness of breath with exertion
Y/N Recurrent cough
Y/N Coughing up blood
Y/N Inability to sleep lying flat
Y/N Recent voice change
Y/N Swollen legs
Y/N Oxygen in use or recommended. How much?_____
What symptoms make you stop walking?_____
How far can you walk without stopping? _____

Past Medical History/Procedures: (Please check off any illnesses or procedure you have had)

___ Rheumatic Fever
___ Hay Fever
___ Heart Attack
___ High Blood Pressure
___ Diabetes
___ Emphysema
___ Asthma
___ Malaria
___ Chronic/recurrent bronchitis
___ Bronchiectasis
___ Pneumonia
___ Allergies
___ Blood clot in your extremities or lung(s)
___ Macrodantin usage
(also known as Macrobid or Nitrofurantoin)
___ Sleep Apnea On CPAP/BIPAP?
___ Kidney Disease
___ Liver Disease
___ Gallbladder
___ Anemia
___ Whooping Cough
___ Chicken Pox
___ Cancer
___ Bronchoscopy or Lung Biopsy
___ Pulmonary Function Testing (e.g. spirometry)
___ Lung Surgery
___ Heart Surgery
___ Tuberculosis or exposure to
___ Amiodarone usage
(also known as Pacerone or Cordarone)

When was your last TB skin test? _____ Was it _____ Positive _____ Negative
Did you have a chest x-ray after the TB skin test? _____ Yes _____ No
If yes, were the results normal? _____ Yes _____ No

Immunizations & Vaccines: (Please check all that you've had and list the year in which you had it.)

	(Year)		(Year)		(Year)
___ Tetanus/booster	_____	___ Influenza	_____	___ Chicken Pox	_____
___ Hepatitis B	_____	___ Pneumococcal	_____		
___ MMR	_____	___ Herpes Zoster	_____		

Name:_____ Date of Evaluation:_____/_____/_____

Surgery:

Name of Surgery	Year	Surgeon	Hospital

☐ If you need more room, check this box and add additional notes on page (9)

Hospitalizations for illness:

Reason	Year	Hospital

☐ If you need more room, check this box and add additional notes on page (9)

Medications: Please list your current medications: (*include any Inhalers, Nebulizers and/or over- the- counter such as vitamins)*

Medication	Strength	Frequency

☐ If you need more room, check this box and add additional notes on page (9)

Allergies to Medications:

Medication	Type of Reaction

☐ If you need more room, check this box and add additional notes on page (9)

Family History:

Family Member	Living	Deceased	Age/Age at Death	Health Problems or Cause of Death
Father				
Mother				
Spouse				
Siblings				

☐ If you need more room, check this box and add additional notes on page (9)

Name: _____ Date of Evaluation:_____/_____/_____

Check any disease that a blood relative may have had:

- □ Heart Disease
- □ High Blood Pressure
- □ Diabetes
- □ Cancer
- □ Asthma
- □ Tuberculosis
- □ Other *(please describe):*
- □ Thyroid Disease
- □ Kidney Disease
- □ Liver Disease
- □ Emphysema
- □ Strokes
- □ Blood clotting disorders
- □ Rheumatoid Arthritis
- □ Scleroderma
- □ Factor V Leiden Mutation
- □ Alpha-1 Antitrypsin Deficiency
- □ Cystic Fibrosis
- □ Lupus

Social History:

Marital Status: (Circle One)
Single / Married / Divorced / Widowed

Children:
Number of children: _____
Any Medical Problems? _____

Living Demographics:
Where did you grow up? _____
Where have you lived most of your life? _____
What is your level of education? _____

Exercise:
Do you exercise regularly? Yes No

History of Alcohol Use:
Do you consume alcohol? Yes No
If so, how many drinks per week? _____

Describe Your Home: *(Circle one).*
House / Apartment / Mobile Home / Other

Problems with water leaks, wet spots, black mold? Yes No
How is home heated?_____

Pets:
Do you have pets in your home? Yes No
Cat(s) / Dog(s) / Bird (s) / Farm Animals

History of Tobacco Use:
Do you smoke cigarettes/cigars? Yes No
If so, how many per day? _____
How many years have you smoked? _____
If you used to smoke, how long ago did you quit? _____
Do you live with a smoker? Yes No

Caffeine Use:
Do you consume caffeine? Yes No
If so, how many drinks per day? _____

Recreational Drug Use:
Do you use recreational drugs? Yes No
If yes, what type and how often? _____
Have you ever used I.V. drugs? Yes No

Employment History:
Are you working now? Yes No
Have you ever been exposed to asbestos, sand or dust at work? Yes No
Have you ever been exposed to radiation or strong fumes? Yes No
Shipyard work? Yes No
Electrician work? Yes No
Plumbing work? Yes No
What jobs have you done? _____
_____
_____

Occupational and Environmental Exposure History: (Please circle Y for Yes or N for No)

Have you ever worked in any of the following occupations or environments?

Y / N	Pulp mill Worker	Y / N	Mica Worker	Y / N	Pipe Coverer
Y / N	Saw mill Worker	Y / N	Smelter	Y / N	Mining
Y / N	Cotton Mill Worker	Y / N	Silica Dust	Y / N	Foundry
Y / N	Woodworker	Y / N	Sandblaster	Y / N	Ship Yards
Y / N	Farming	Y / N	Carpenter	Y / N	Pottery Worker
Y / N	Radiation	Y / N	Painter	Y / N	Talc Worker
Y / N	Asbestos Abatement Worker	Y / N	Insulation Worker	Y / N	Beryllium Worker
Y / N	Insulation Product Manufacturing	Y / N	Aluminum Worker	Y / N	Plastic Worker
Y / N	Umatilla Army Depot Worker	Y / N	Textile Manufacturing	Y / N	Railroad Worker

Y / N Hanford Worker - Wash. State

Name: _____ Date of Evaluation: _____/_____/_____

Review of Systems: (Please check off any symptom(s) that you are experiencing)

Constitutional:
____ Lack of energy
____ Weight gain
____ Weight loss
____ Fevers
____ Chills
____ Night sweats
____ Daytime sleepiness
____ Trouble sleeping
____ Weakness
____ Loud snoring
____ Breathing difficulty while sleeping (apnea)

Ophthalmologic:
____ Wears glasses/contacts
____ Watering/irritation of eyes
____ Cataracts
____ Glaucoma
____ Vision Changes

ENT:
____ Difficulty hearing
____ Earache
____ Buzzing or ringing in ears
____ Nasal stuffiness
____ Nose bleeds
____ Persistent hoarseness
____ Sore or bleeding gums
____ Sore tongue
____ Wears dentures or partials
____ Sinusitis

Respiratory:
____ Shortness of breath
____ Wheezing
____ Raises phlegm
____ Cough up blood
____ Daily cough
____ Asthma
____ Emphysema
____ Recurrent bronchitis
____ Tuberculosis
____ Pneumonia
____ Fluid around lungs
____ Scarring of lungs

Immune System:
____ Multiple infections
____ Immune deficiency
____ Seasonal allergies

Cardiac:
____ Chest pain/angina
____ Irregular heartbeat/murmur
____ High blood pressure
____ Heart attack
____ Leg swelling/pain
____ Circulation problems

Gastrointestinal:
____ Poor appetite
____ Trouble swallowing
____ Painful swallowing
____ Heartburn
____ Stomach ulcer/pain
____ Indigestion
____ Constipation
____ Diarrhea
____ Nausea
____ Vomiting
____ Hemorrhoids
____ Black stools
____ Blood in stools
____ Jaundice
____ Liver problems
____ Pancreas problems
____ Gallstones
____ Vomiting blood
____ Hepatitis

Genitourinary:
____ Getting up more than once a night to urinate
____ Trouble starting stream
____ Trouble emptying bladder
____ Blood in urine
____ Venereal disease
____ Kidney or bladder stones
____ Impotence

Musculoskeletal:
____ Joint pain, swelling or redness
____ Arthritis
____ Back pain
____ Muscle pain
____ Gout
____ Osteoporosis
____ Phlebitis

Dermatologic:
____ Rash
____ Skin cancer
____ Skin infections
____ Acne
____ Nonhealing ulcer

Endocrine:
____ Diabetes
____ Thyroid disease
____ High cholesterol
____ Excessive thirst
____ Excessive hunger
____ Adrenal gland problems

Hematologic:
____ Easy bleeding or bruising
____ Anemia
____ Clotting disorder
____ Previous transfusions
____ Blood clots in legs
____ Blood cancer

Neurologic:
____ Stroke
____ Seizures
____ Paralysis
____ Numbness of hands
____ Numbness of feet
____ Memory loss
____ Loss of consciousness
____ Headaches
____ Balance problems
____ General weakness
____ Localized weakness

Psychiatric:
____ Hallucinations
____ Feeling depressed
____ Suicidal thoughts
____ Suicide attempt
____ Anxiety
____ Nervous or upset
____ Insomnia

Gynecologic: (Female Only)
____ Breast lumps, masses
____ Breast cancer
____ Recent mammogram
____ Recent Pap smear
____ Recent pelvic exam
____ Menopause
____ Hysterectomy
____ Hormone therapy
____ Birth control pills

801 MISSION ST. SE, SALEM, OREGON 97302
(503) 588-3945
FAX (503) 588-0256

Name:_____ Date of Evaluation_____/_____/_____/

Activities of Daily Living: (Are you experiencing any of the following – Circle Y for Yes and N for No?)

Y / N Difficulty with bathing, dressing or feeding yourself?
Y / N Difficulty with showering, vacuuming, or making the bed?
Y / N Difficulty getting out of chairs or bed?
Y / N Decreased movement or strength in your arms or legs?
Y / N Have you fallen in the last month, or have balance problems?
Y / N Has it been more than 5 years since you obtained a new wheelchair?
Y / N Do you often choke on food, liquids or pills?
Y / N Do you have difficulty communicating your needs to others?
Y / N Decrease in the loudness of your voice or ability to speak clearly?

Patient Medical/Legal Health Care Documents and Directives:

Y / N Do you have a Living Will or Advance Directive?
Y / N Do you have an Organ Donor Card designated on your Oregon Driver's license?
Y / N Do you have a Healthcare Power of Attorney?
Y / N Full Resuscitation
Y / N Do Not Resuscitate
Y / N No ventilator support
Y / N General Medical Care Only

What are your general thoughts about end of life care? _____

_____

_____

Would you like a copy of our report to go to any other doctors? *(Please List below)*

1.
2.
3.

Please use this space to fill in any details from prior pages where you required extra room for documentation.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Salem Pulmonary Associates, PC & Sleep Center

MARTIN C JOHNSON MD
KAMRAN FIROOZI MD
FAYEZ BADER MD

Patient Sleep Questionnaire (STOP BANG)

Please answer the following questions to find out if you are at risk for Obstructive Sleep Apnea (OSA)

STOP

S (snore)	Have you been told that you snore?	Yes / No
T (tired)	Are you often tired during the day?	Yes / No
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes / No
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	Yes / No

If you answered yes to two (2) or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea

To find out if are at moderate to severe risk of OSA, complete the BANG questions below:

BANG

B (BMI)	Is your body mass index greater than 28?	Yes / No
A (age)	Are you 50 years old or older?	Yes / No
N (neck)	Are you a male with a neck circumference greater than 17 inches or a female with a neck circumference greater than 16 inches?	Yes / No
G (gender)	Are you a male?	Yes / No

The more questions you answer yes to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

Name: _____Date of Evaluation____/____/____/

This Section For SPA Physician and Medical Staff Documentation

PHYSICAL EXAMINATION:

Gen'l Appear _____Wt. _____Ht _____HR _____BP(arm/position) _____RR_____

WNL N=Normal A=Abnormal D=Deferred	**Description of Abnormal Findings**
☐ (3) **Nose:** Mucosa _____ Turb ____ Septum_____ Sinuses _____	
☐ **Mouth:** Mucosa _____ Teeth_____ Gingiva ____	
☐ **Throat:** Palate ____ Tongue____ Tonsils_____ Post. pharynx ____	
……	……
☐ (3) **Neck:** Appear ____ Thyroid ____ Jugular vein _____	
……	……
☐ (5) **Resp:** Sym/Exp _____ Effort _____ Percuss'n _____ Palp'n_____ Auscult'n _____	
……	……
☐ (1) **Heart:** Rate _____ Rhythm_____ S_1/S_2 _____ Murmur_____ Rub _____ Gallop _____	
……	……
☐ (2) **Abdomen:** Appear _____ Tenderness _____ Masses _____ Scars _____ Spleen _____ Liver _____	
……	……
☐ (1) **PVS:** Appear ____ Pulses _____ Edema _____Carotid Art ___	
……	……
☐ (1) **Extr:** Clubbing ____ Cyanosis _____Ulcers ____ Tenderness ____	
……	……
☐ (1) **Skin:** Rash _____ Lesions _____ Ulcers _____ Bruising _____	
……	……
☐ (2) **MS:** Strength _____ Tone _____ Movements _____ Atrophy _____ Gait _____ Station _____	
……	……
☐ (2) **Neuropsych:** Orient'n _____ Affect _____	
……	……
☐ **Chest (Breasts):**	
……	……
☐ **GU:**	

Notes: _____

_____

_____

_____

_____

_____

_____

_____

Name: _____Date of Evaluation___ _/____/____/

PHYSICIAN MEDICAL DECISION MAKING: (For Medical Personnel Use Only)

Data Reviewed: _____/_____/_____

□ **Chest radiographs:**
- □ Office (date) _____
  Dictated? □ Yes
- □ Outside (date) _____

□ **Chest CT Scan (date) _____**

□ **Awake oximetry (date) _____**

□ **Overnight oximetry** (date) _____
- □ Office (date) _____
- □ Outside (date) _____

□ **VQ Scan (date) _____**

□ **PET/SPECT Scan (date**) _____

□ **Bronchoscopy (date) _____**

□ **PSG/MSLT (date) _____**

□ **Blood Tests/Other (specify & date):**

_____ _____
_____ _____
_____ _____
_____ _____

□ **Pulmonary Function Tests**
- □ Spirometry
- □ Office (date) _____

□ **Lung Volumes**
- □ Office (date) _____
- □ Outside (date) _____

□ **Diffusing Capacity**
- □ Office (date) _____
- □ Outside (date) _____

□ **Methacholine Challenge Testing**
- □ Office (date) _____
- □ Outside (date) _____

□ **ABG (date) _____**

□ **Exercise Stress Testing (date)____**

□ **6 Minute Walk Test (date)_____**

□ **Echocardiogram (date) _____**

□ **Thoracentesis (date) _____**

IMPRESSION:

PLAN: