GUPTA MEDICAL CENTER
RAMONA MEDICAL CLINIC & RAMONA SPECIALISTS, INC.

www.guptamedicalcenter.com

Ramona Medical Clinic
Patient First Physicians Group

Main Office: 341 E Main Street, Suite 100, San Jacinto, CA 92583 • Tel: (951) 654-9367 Fax: (951) 654-0839
Sun City Office: 27994 Bradley Road, Suite E, Sun City, CA 92586 • Tel: (951) 672-8384 Fax: (951) 672-1566

REGISTRATION FORM - PATIENT INFORMATION

Today's Date:	Primary Care Physician:				
Patient's Last Name:	First Name:	Middle:	Marital Status (Mark One) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name? (Former name):	Birth Date:	Age:	Sex: ☐ M ☐ F	
Street Address:	City:	State and Zip Code:			
Social Security Number:	Home Phone No.:	Cell Number:			
Occupation:	Employer:	Email for Patient Portal:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person Responsible for Bill:	Birth Date:	Address (if different):	Home Phone No.:
Occupation:	Employer:	Employer Address:	Employer Phone No.:

Is this patient covered by insurance? ☐ Yes ☐ No

Primary Insurance: ☐ Medicare ☐ Medi-Cal / Medicaid ☐ IEHP ☐ Other: ______

Subscriber's Name:	Subscriber's SSN & Birth Date:	Policy / ID Number:	Group No.:	Co-Payment: $

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (if applicable):	Subscriber's Name:	Policy / ID No.:	Group No.:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at the same address):	Relationship to Patient:	Home Phone No.:	Work Phone No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ramona Medical Clinic or insurance company to release any information required to process my claims.

Patient / Guardian (PRINT NAME):	*Date:*
Patient / Guardian Signature:	*Date:*

Symptoms - *Check all that apply*

GENERAL
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Chills
- ☐ Diarrhea
- ☐ Depression
- ☐ Dizziness
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Gas
- ☐ Hemorrhoid
- ☐ Headache
- ☐ Indigestion
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Rectal Bleeding
- ☐ Sweats
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

URINARY
- ☐ Blood in Urine
- ☐ Bladder Control
- ☐ Painful Urine

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleed
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Flashes
- ☐ Vision Halos

MUSCLE/BONE
Pain or Weak
- ☐ Arms ☐ Hands
- ☐ Back ☐ Hips
- ☐ Legs ☐ Feet
- ☐ Neck

SKIN
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Hives ☐ Rash
- ☐ Itching ☐ Scar

SLEEP
- ☐ Snoring
- ☐ Daytime Sleepiness/Naps
- ☐ Do You Wake Up Frequently at Night?
- ☐ Witness Sleep Apnea
- ☐ Neck Collar Size: ________
- ☐ Gasping for Air
- ☐ Sleep Quality
- ☐ Weight Gain Last 1 Year

Conditions - *Check what you currently have*

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependence
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV+
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

WOMEN ONLY

Have you had a mammogram? ☐ Yes ☐ No If yes, when? ________

Date of last menstruation ________ Pap. ________ & Rectal exam ________

Number of pregnancies? ________ Number of live births? ________

Question		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have any menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

Other concerns / issues?

MEN ONLY

Question		
Do you usually get up to urinate during s night? If yes, # of times ________	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain, swelling, or lumps?	☐ Yes	☐ No

Date of last prostate exam ________ & Rectal exam ________

Other concerns / issues?

Please List All Medications Including Frequency & Dosage:

Medication Name	Frequency	Dosage

Please List All Allergies

Notice of Privacy Practices

(MEDICAL)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Healthcare Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As requited by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use & disclose your medical records only got each of the following purposes: treatment, payment & health care operations.

- Treatment means providing, coordinating, or managing health care & related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverages, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of funning our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminder or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction if we do agree to a restriction, we must abide by it unless you agree with in writing and remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations
- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to obtain a paper copy of this notice from us upon request

Notice of Privacy Practices Acknowledgment

I understand that, under the Healthcare Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received you Notice of Private Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Private Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health operation. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Date: ____________________

Patient Name (PRINT): ____________________________________ Signature: _______________________________________

Communications Consent Form

I understand that under the federal law (HIPPA), this medical office may not release any medical information to any individual, without my written permission. Law enforcement and court order are two exceptions to this requirement.

I, therefore, give permission to this office to release medical information on my behalf, to the following person(s)

Name: ____ Relation: ____

Address: ____

Phone Number: ________________________________ Age/Date of Birth: ____

☐ You CAN share information with the person listed
☐ You CAN ONLY share information regarding ____
☐ Do NOT share my information with the person listed

Patient Name (PRINT): ____

Signature: ____ Date: ______________________________________

Authorized Methods of Communication: ☐ Telephone ☐ Written ☐ Present

Office Use Only

I attempted to obtain the patients signature in acknowledgment of this notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date: ___________________________ Initials: _________ Reason: ____

Advance Directives — The Patients Right to Decide

All adult individuals in hospitals, nursing homes, and other health care settings have certain rights. You have the right to fill out a paper known as an "advance directive". The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions—conditions that would prevent you from telling your doctor how you want to be treated. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know your specific wished about decisions affecting your treatment?

What is an Advance Directive?

Generally, an advance directive is a written statement, which you can complete in advance of serious illness or injury, about how you want medical decisions made. The two most common forms of advance directives are:

- Living will
- Durable Power of Attorney for Health Care

An advance directive allows you to state your choices about health care or to name someone to make those decisions for you if you become unable to make those decisions about your medical treatment. An advance directive can enable you to make decisions about your future medical treatment.

What is a living Will?

A Living Will generally states the kind of medical care you want (or don't want) if you become unable to make your own decisions. It is called a living will because it takes affect while you are still living. California law provides a suggested form for a living will ***(see link below)***; you may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way so that your wishes will be understood and followed.

Living will PDF link:

https://oag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirectiveForm-fillable.pdf

What is a Durable Power of Attorney for Health Care?

A signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent or proxy to make medical decisions for you if you should become unable to make them yourself. You can include instruction about any treatment you want to wish to avoid. Some states have specific laws allowing a health care power of attorney and provide printed forms.

Which is better: A Living Will or a Durable Power of Attorney for Health Care?

In some states, laws may make it better to have one or the other. It may also be possible to have both, or to combine them in a single document that describes treatment choices in a variety of situations (ask your doctor about these) and name someone (called agent or proxy) to make decisions for you, should you be unable to make decisions for yourself.

How do I make my advance health care directive legal?

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself. Your signature must be witnessed by you must acknowledge your signature before a notary public or two adult witnesses. Your two adult witnesses may not be: your health care provider or an employee of your health care provider, the operator or an employee of a community care facility, the operator or an employee of a residential care facility for the elderly, or the person you have appointed as an agent, if you have appointed an agent. In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate.

What if I change my mind?

Except for the appointment of your agent, you may revoke any portion or this entire advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke, by signing a revocation, or simply by tearing up your advance directive. In order to revoke your agent's appointment, you must either tell your supervising health care provider of your intent to revoke or revoke your agent's appointment in a signed writing.

Advance Directives Acknowledgment

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Telephone: ______________

☐ I do have an existing ☐ Living Will or ☐ Durable Power of Attorney for Health Care

☐ I do not have an existing ☐ Living Will or ☐ Durable Power of Attorney for Health Care

Physician: ______________________________

Physician Address/Telephone: ☐ 341 E Main St, Suite 100, San Jacinto, CA 92583 (951) 654-9367

☐ 27994 Bradley Road, Suite E, Sun City, CA 92586 (951) 672-8384

☐ Other: ______________________________

This acknowledgment that the physician or one of his/her staff members has provided me information concerning advance directives.

1. I am of age 18 years or older? ☐ Yes ☐ No
2. I realize I have the option of putting together Advance Directives for my healthcare. My physician has provided me written information concerning these Advance Directives. I understand that it is my responsibility to provide my doctors with my documents that are required to carry out my Advance Directives.
3. I am aware that Advance Directives may be any one of the following:
   - A Durable Power of Attorney for Health Care
   - The declaration in the A natural death act - ex. A Living Will
   - I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event that I am unable to do so.

Patient Signature: ______________________________ Date: ______________

This document will become part of my medical record.

Adult TB (Tuberculosis) Risk Assessment

You may be at increased risk for TB if you answer YES to any of the following questions:

A person at risk for TB should have a test yearly.	Date	Date	Date	Date
1. Do you have a family member or close contact with history of confirmed or suspected TB?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Are you from Asia, Africa, Central America, or South America? *(these areas have a higher prevalence of TB)*	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Do you live in an "out of home" placement facility?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Do you have a history of confirmed or suspected HIV infection?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Do you live with any individual who is HIV positive?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you been, or do you live with any individual who has been incarcerated in the last 5 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you live among, or are you frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or a resident in a nursing home?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Name: ______________________ *Date:* ______________________

Staying Healthy Assessment

Adult

State of California - Health and Human Services Agency

Department of Health Care Services

Patient's Name *(first & last)*	Date of Birth	☐ Female ☐ Male	Today's Date

Person Completing Form *(if patient needs help)* ☐ Family Member ☐ Friend ☐ Other *(specify)*	Need help with form? ☐ Yes ☐ No

Please answer all of the questions on this form as best you can. Circle "skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have any questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

		YES	NO	SKIP	*Clinic Use Only:*
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?				Nutrition
2	Do you eat fruits and vegetables every day?				
3	Do you limit the amount of fried food or fast food that you eat?				
4	Are you easily able to get enough healthy food?				
5	Do you drink a soda, juice drink, sports, or energy drink most days of the week?				Physical Activity
6	Do you often eat too much or too little food?				
7	Are you concerned about your weight?				
8	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for a half hour a day?				
9	Do you feel safe where you live?				Safety
10	Have you had any car accidents lately?				
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?				
12	Do you always wear a seatbelt when driving or riding in a car?				Dental Health
13	Do you keep a gun in your house or place where you live?				
14	Do you brush and floss your teeth daily?				Mental Health
15	Do you often feel sad, hopeless, angry, or worried?				
16	Do you often have trouble sleeping?				
17	Do you smoke or chew tobacco?				Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?				

		YES	NO	SKIP	
19	In the Past year have you had: ☐ ***(men)*** *5 or more alcoholic drinks in one day?* ☐ ***(women)*** *4 or more alcoholic drinks in one day?*				
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?				
21	Do you think you or your partner could be pregnant?				Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?				
23	Have you or your partner(s) had sex without using birth control in the past year?				
24	Have you or your partner(s) had sex with other people in the past year?				Other Questions
25	Have you or your partner(s) had sex without a condom in the past year?				
26	Have you ever been forced or pressured to have sex?				
27	Do you have other questions or concerns about your health? *If yes, please describe:*				

Clinical Use Only	Counseled	Referred	Anticipatory Guidance	Follow-Up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name	Date

SHA ANNUAL REVIEW

PCP's Signature	Print Name	Date
PCP's Signature	Print Name	Date
PCP's Signature	Print Name	Date
PCP's Signature	Print Name	Date

Please review the following and initial each point that you have read and understood the information on this page.

Prescription Information:

________ It is the patient's responsibility to address all medication/refills issues at the time of your appointment and to know when medications are due; early medication refills will NOT be permitted.

________ Office Policy: The physicians WILL NOT replace expired, lost, misplaced, stolen controlled substance prescriptions (RX) or medications

________ Office Policy: We DO NOT do Prior Authorization for controlled medications and/or cough medicine.

________ If your prescriptions require prior authorization your pharmacy must fax the denial/request to our office. Requests may take up to 72 hours.

________ All patients on narcotics or any controlled substance are expected to agree to sign our controlled substance contract also known as Medication / Pain Contract.

________ Any change to increasing or changing medication treatment will require a follow-up visit for re-evaluation.

________ Refills will not be given if you have not had a follow-up visit in the last 3 months.

________ There will be no refills on weekends or after hours by any of our on-call physicians or providers for any reason. The on-call providers are to be called for emergencies only.

Referrals:

________ In order to be referred to a specialist your primary care physician must document and request it during your appointment.

________ Referrals may take up to 7-10 days to submit from the date of service and take 5-7 for your insurance to approve.

________ Urgent or Expedited referrals are submitted within 3 days and take 72 hours for your insurance to approve.

No Show/Missed Appointments:

________ If you are unable to keep an appointment, please call as soon as possible to reschedule/cancel or it will be considered a missed appointment.

________ In consideration of our other patients, if you are more than 15 minutes late for your appointment, we will try to fit you in or you will need to be rescheduled or wait listed.

________ If you have three (3) or more No Shows or Cancellations without notice, we have the right to deny you further appointments.

Messages:

________ When leaving a voicemail please leave your name, date of birth and a brief message of what you need

________ All calls after 3:00 pm will be returned the next business day.

________ If you call and leave us a message, there is no need to leave multiple messages throughout the day.

Completion of Forms and Letters

Completed forms and medical letters will only be written/filled out at an appointment. If you forgot your forms at the time of your appointment you will be scheduled the next available appointment to complete the forms. NO EXCEPTIONS. The payment is due at time the forms are to be picked up. The chargers for completion of these forms are as follows.

- School Physical - $40.00
- DMV Physical - $60.00

I have read the above policies and I understand them. Date: ______________________

Patient Name: ______________________ Patient Signature: ______________________

Sleep Disorder Symptoms Assessment

Name: ____________________

Date of Birth (M/D/Y) ______/______/______ Gender: ☐ M ☐ F

FOR OFFICE USE

Height: ____________________
Weight: ____________________
BMI: ____________________
Neck Size: ____________________
Blood Pressure: ____________________

Please check any of the following you may have:

☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night (Nocturia)	☐ Diabetes	☐ Depression	☐ Overweight

Snoring:				Score
1. Do you snore often (3 or more nights a week)?	☐ YES	☐ NO	☐ Don't Know	______ Yes =1
2. Is your snoring loud enough to be heard through a closed door or annoy other people?	☐ YES	☐ NO	☐ Don't Know	______ Yes =1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air?	☐ YES	☐ NO	☐ Don't Know	______ Yes =1

Epworth Sleepiness Scale:	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0☐	1☐	2☐	3☐
2. Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3. While sitting or inactive in a public place (meeting, theater)?	0☐	1☐	2☐	3☐
4. As a passenger in a car for an hour without a break?	0☐	1☐	2☐	3☐
5. Lying down to rest for the afternoon?	0☐	1☐	2☐	3☐
6. Sitting and talking to someone?	0☐	1☐	2☐	3☐
7. Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8. In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
			(sum of all numbers checked score) Total Score	

CPAP:

Are you currently using CPAP: ☐ YES ☐ NO If yes, for how long? __________

HeMacinto Sound Sleep Center
951-654-5592

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Release of Medical Records for:

Patient's Full Name: ______________________________ Date of Birth: ____________________

Requesting Medical Records from which physician / office (include telephone or fax):

____

____

____

____

I hereby authorize you to release the medical records of the above named patient to:

________ Rakesh C. Gupta, M.D.
Pulmonary, Critical Care,
Sleep Medicine

________ Neelam Gupta, M.D.
Internal Medicine, Geriatric

☐ All Medical Records
☐ Psychiatric/Drug Abuse
☐ X-Rays
☐ Operative Reports
☐ Lab Work
☐ Other: ________________

This authorization is valid until ______________. I understand that I am entitled to a copy of this authorization.

____
Patient Signature

____
Date

____
Witness Signature

____
Date

PLEASE MAIL - DO NOT FAX

The information contained in this fax may contain information that is privileged, confidential and is intended only for the use of the individual/entity named above. If the reader of this message is not the intended recipient, please notify us immediately: you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.