Ramona Specialist INC.
Patient First Physicians Group

Rakesh C. Gupta, MD., F.C.C.P., F.A.C.P.
341 E Main ST #100 San Jacinto CA, 92583
Phone: 951-487-1385

PATIENT INFORMATION

First Name: ____________ Last Name: ____________ DOB: ____________

Sex: ☐ Female ☐ Male Age: ________ SS #: ____________

Phone Number: ____________ Email Address: ____________

Address: ____________

City: ____________ State ____________ Zip Code: ____________

Primary Care Physician: ____________ Referring Physician: ____________

Emergency Contact: ____________ Relationship: ____________

Address: ____________ Phone #: ____________

PRIMARY INSURANCE INFORMATION

Name of Primary Insured: ____________ DOB: ____________

Relationship to Patient: ____________ SS #: ____________

Name of Insurance Company: ____________ Phone #: ____________

Insurance ID: ____________ Group #: ____________

ADDITIONAL INSURANCE INFORMATION

Name of Primary Insured: ____________ DOB: ____________

Relationship to Patient: ____________ SS #: ____________

Name of Insurance Company: ____________ Phone #: ____________

Insurance ID: ____________ Group #: ____________

ASSIGNMENT AGREEMENT

I certify that I and/or my dependents have insurance coverage with the companies given and I assign to doctors all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I authorize the us of my signature on all insurance submissions.

Signature: ____________ Date: ____________

First Name: ______________ Last Name: ______________ DOB: __________

Please answer the following questions to help your doctor evaluate you.

I. Pulmonary History

Reviewed with patient by physician: (initials) __________

CHECK ALL THAT CURRENTLY APPLY:

- ☐ Intermittent cough (not related to a common cold)
- ☐ Frequent cough in the morning
- ☐ Sputum production (____ tablespoons per day)
- ☐ Coughing up blood
- ☐ Chest congestion/tightness
- ☐ Positive TB skin test in the past
- ☐ Exposure to TB
- ☐ Pneumonia (Date: __________)

Wheezing:

- ☐ Following a common cold
- ☐ With exercise
- ☐ Seasonally (spring/fall)

Smoking History

- ☐ Never smoked
- ☐ Quit smoking
  - When? __________
  - Average packs per day: __________
  - Number of years smoked: __________
- ☐ Currently smoking
  - Average packs per day: __________
  - Number of years smoked: __________

Shortness of Breath:

- ☐ During strenuous exercise
- ☐ During moderate exercise
- ☐ During normal activity
- ☐ While at rest
- ☐ Awake at night

Number of blocks on level you can walk: __________
Number of flights of stairs you can climb: __________
Date of last chest x-ray: __________
Date of last pneumococcal pneumonia vaccine: __________
Date of last influenza vaccine: __________

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

II. Your Past Medical History

Birthplace: __________

Previous Surgery (check and describe)

- ☐ Lung surgery __________ Year: ______
- ☐ Heart surgery __________ Year: ______
- ☐ Other surgery __________ Year: ______

____
____
____
____
____
____
____

Other Medical Disease (check and describe)

- ☐ High blood pressure __________ Year: ______
- ☐ High cholesterol __________ Year: ______
- ☐ Cancer __________ Year: ______
- ☐ Heart Disease __________ Year: ______
- ☐ Thyroid Disease __________ Year: ______
- ☐ HIV Disease __________ Year: ______
- ☐ Valley Fever __________ Year: ______
- ☐ Other: __________ Year: ______

____
____

III. Your Family History

What diseases run in your family? Please indicate which relatives are affected.

- ☐ Allergies __________
- ☐ Ephysema __________
- ☐ Asthma Bronchitis __________
- ☐ Heart Disease __________
- ☐ Cancer __________
- ☐ Other: __________

____

IV. Your Social History

Are you working now? ☐ Yes ☐ No

What is/was your occupation and occupational history? ____________________

____

Have you ever been exposed to asbestos, dust, or strong chemicals? ☐ Yes ☐ No

Do you keep animals at home? ☐ Yes ☐ No Please describe: ____________________

Approximately how many drinks of alcohol do you consume in a week? ____________________

Have you traveled in the last year? (list places and dates) ____________________

____

V. Medications

____
____
____
____
____
____

VI. Allergies

____
____
____
____
____
____

VII. Review of Symptoms, Other Than Your Breathing Problem

What diseases run in your family? Please indicate which relatives are affected.

- ☐ Allergies
- ☐ Fever, sweats, or chills
- ☐ Unusual fatigue
- ☐ Loss of appetite
- ☐ Weight loss of more than 5 pounds
  - Number of pounds: ____________________
- ☐ Weight gain of more than 5 pounds
  - Number of pounds: ____________________
- ☐ Headaches
- ☐ Earaches
- ☐ Hearing difficult/ringing in the ears
- ☐ Eye irritation
- ☐ Blurred double vision
- ☐ Nose or sinus problems
- ☐ Postnasal drip
- ☐ Dry eyes or mouth
- ☐ Sleepiness in the daytime
- ☐ Breast discomfort
- ☐ Chest pain
- ☐ High cholesterol
- ☐ Irregular or rapid heart beats
- ☐ Heart murmur
- ☐ Heartburn or indigestion
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Hiatal hernia, gastroesophageal reflux
- ☐ Diarrhea
- ☐ Nausea or vomiting
- ☐ Swelling at the ankles
- ☐ Joint pain or muscle aches
- ☐ Fingers turn white and painful in cold
- ☐ Morning stiffness
- ☐ Back or neck pain
- ☐ Unusual dizziness, faintness, or loss of consciousness
- ☐ Seizures
- ☐ Numbness or weakness of part of your body
- ☐ Rashes/skin problems
- ☐ Anxiety
- ☐ Depression
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Anemia
- ☐ Lymph gland swelling
- ☐ Constipation
- ☐ Liver disease
- ☐ Difficult or painful urination
- ☐ Frequent urination
- ☐ Irregular menstrual periods/vaginal bleeding
- ☐ Hospitalization
- ☐ Other symptoms: ____________________

Signature: ____________________ Date: ____________________

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? ________

COMMUNICATION CONSENT FORM

I UNDERSTAND THAT UNDER 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, GIVE PERMISSION TO **RAMONA SPECIALISTS INC** TO RELEASE MEDICAL INFORMATION ON MY BEHALF TO THE FOLLOWING PERSON(S):

NAME: ______________________________ RELATION TO PATIENT: ______________

DOB: ______________________ PHONE #: ____________________________

ADDRESS: ____

____

NAME: ______________________________ RELATION TO PATIENT: ______________

DOB: ______________________ PHONE #: ____________________________

ADDRESS: ____

____

NAME: ______________________________ RELATION TO PATIENT: ______________

DOB: ______________________ PHONE #: ____________________________

ADDRESS: ____

____

NAME: ______________________________ RELATION TO PATIENT: ______________

DOB: ______________________ PHONE #: ____________________________

ADDRESS: ____

____

AUTHORIZED METHODS OF COMMUNICATION TO THE ABOVE NAMED PERSON(S)

- TELEPHONE
- WRITTEN
- PRESENT

PATIENT NAME: ____

SIGNATURE: ______________________________________ DATE: ______________

ADVANCE DIRECTIVE STATUS

I HAVE BEEN INFORMED OF MY RIGHT TO FORMULATE AN ADVANCE DIRECTIVE AND I HAVE BEEN PROVIDED WITH INFORMATION REGARDING THE EXECUTION OF AN ADVANCE DIRECTIVE.

PLEASE CHECK ONE:

_________ I HAVE PREVIOUSLY COMPLETED AN ADVANCE DIRECTIVE AND HAVE PROVIDED A COPY FOR INCLUSION IN MY RECORDS.

_________ A COPY OF MY ADVANCE DIRECTIVE IS IN FILE WITH ____

_________ I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE AND I AM NOT INTERESTED IN ANY FURTHER INFORMATION.

_________ I AM INTERESTED IN THE FORMULATION OF AN ADVANCE DIRECTIVE AND I WILL DISCUSS MY OPTIONS WITH MY PRIMARY CARE PROVIDER.

____ ____________________________
PATIENT SIGNATURE DATE

COMMENTS:

____

____

____

____

_________ THE PATIENT WAS GIVEN A BROCHURE INFORMATION ON ADVANCE DIRECTIVES

____ ____________________________
STAFF SIGNATURE DATE

____ ____________________________
PATIENT NAME DOB

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: ____________________________________

Ramona Medical Clinic & Ramona Specialists Inc.
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

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
- ☐ X-Rays
- ☐ Lab Work
- ☐ Psychiatric/Drug Abuse
- ☐ Operative Reports
- ☐ 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.