- Office Consultation
- Pulmonary Function Tests
- Chest Radiology
- Bronchoscopy, Thoracentesis
- Lung Biopsies
- Critical Medicine
- Sleep Medicine

GENESEE LUNG ASSOCIATES

G. BAYASI, M.D. – M. ABOUDAN, M. D. – M. AL-ALI, M.D. – O. KHORFAN, D.O.
A. WAQAS, M.D. – D. ZAKRI, M.D.
Pulmonary, Critical Care and Sleep Medicine
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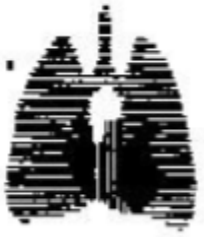

WELCOME TO GENESEE LUNG ASSOCIATES

Your appointment is on _____ with _____**at**_____**.**

Enclosed is the new patient paperwork. Please **fill it out** and **bring it to your appointment** along with the following items:

1) Insurance Card(s)

2) If your insurance is an HMO, please make sure that your referral has been put in through your primary care physician's office. Without a referral you are unable to be seen.

3) List of all your medications and dosages (see attached sheet).

4) If you have any recent chest x-rays or chest CT scan within the last 6 months at a facility other than Regional Medical Center, Ascension Genesys Medical Center or Ascension Genesys Ambulatory Imaging, please bring the actual films or a disc not just the report.

5) **IF FOR ANY REASON YOU ARE UNABLE TO KEEP THIS APPOINTMENT, WE NEED TO HAVE A 24 HOUR IN ADVANCE NOTICE OR YOU WILL BE CHARGED A $40.00 NO SHOW FEE. THANK YOU FOR YOUR COOPERATION.**

We look forward to seeing you at our office. Please take note, if you are 15 minutes late for your appointment you may need to reschedule it will be up to the physician that you are scheduled to see.

If your appointment was set up by PCP and you need to reschedule please let us know.

HEALTH HISTORY FORM

PAGE 1

Name: _____ DOB: _____

(**Please Print)**

SELF MEDICAL HISTORY (PLEASE CIRCLE ***ALL*** THAT APPLY)

ANEMIA
ARTHRITIS
KIDNEY DISEASE
BACK PROBLEMS
BLEEDING TENDENCY
PLEURISY
CHRONIC BRONCHITIS
CANCER (WHAT TYPE?) _____
DIABETES (WHAT TYPE?) _____
SLEEP APNEA
GOUT
HAY FEVER

ASTHMA
HIGH BLOOD PRESSURE
MENINGITIS
NOSE BLEEDS
HEART DISEASE
PNEUMONIA
ACID REFLUX
RHEUMATIC FEVER
HEPATITIS
THYROID DISORDER
TB OR TB EXPOSURE

SURGICAL HISTORY

LUNG
BACK
PROSTATE
BRONCHOSCOPY
GALLBLADDER
HEART
HERNIA REPAIR

NASAL POLYP
BREAST
THYROIDECTOMY
TONSILLECTOMY
VARICOSE VEINS
HYSTERECTOMY
APPENDECTOMY

HEALTH HISTORY FORM

PAGE 2

Name _____ DOB _____

(Please Print)

FAMILY HISTORY (PLEASE CIRCLE ***ALL*** THAT APPLY)

ALLERGIES	FATHER	MOTHER	BROTHER	SISTER
ANEMIA	FATHER	MOTHER	BROTHER	SISTER
ASTHMA	FATHER	MOTHER	BROTHER	SISTER
BLEEDING TENDENCY	FATHER	MOTHER	BROTHER	SISTER
BRONCHITIS	FATHER	MOTHER	BROTHER	SISTER
ARTHRITIS	FATHER	MOTHER	BROTHER	SISTER
SEIZURE	FATHER	MOTHER	BROTHER	SISTER
CANCER	FATHER	MOTHER	BROTHER	SISTER
	TYPE? _____			
DIARRHEA	FATHER	MOTHER	BROTHER	SISTER
EMPHYSEMA	FATHER	MOTHER	BROTHER	SISTER
HIGH BLOOD PRESSURE	FATHER	MOTHER	BROTHER	SISTER
HAY FEVER	FATHER	MOTHER	BROTHER	SISTER
HEART DISEASE	FATHER	MOTHER	BROTHER	SISTER
LEUKEMIA	FATHER	MOTHER	BROTHER	SISTER
OVERWEIGHT	FATHER	MOTHER	BROTHER	SISTER
ACID REFLUX	FATHER	MOTHER	BROTHER	SISTER
THYROID DISORDER	FATHER	MOTHER	BROTHER	SISTER

HEALTH HISTORY FORM

PAGE 3

Name _____ DOB _____

(**Please Print**)

TOBACCO ASSESSMENT

SMOKING STATUS (PLEASE CIRCLE)

CURRENT EVERYDAY SMOKER

OF PACKS PER DAY_____ FOR HOW MANY YEARS _____

CURRENT SOMEDAY SMOKER

OF PACKS PER DAY_____ FOR HOW MANY YEARS _____

FORMER SMOKER

OF PACKS PER DAY_____FOR HOW MANY YEARS _____YEARS QUIT_____

NEVER SMOKED

SOCIAL HISTORY (PLEASE CIRCLE ***ALL*** THAT APPLY)

ALCOHOL USE

NON-DRINKER

OCCASIONAL

SOCIAL

MODERATE CONSUMPTION

SEVERE CONSUMPTION

CAFFEINE USE

COFFEE

TEA

SODA

Do you live alone? Y or N

Do you have any children? Y or N

Do you have any pets? Y or N

Current or past drug abuse? Type? _____

_____

WORK HISTORY(PLEASE CIRCLE)

EMPLOYED UNEMPLOYED RETIRED DISABLED STUDENT

HEALTH HISTORY FORM

PAGE 4

Name _____DOB _____

(**Please Print**)

MEDICATION

DRUG ALLERGIES Y or N (If yes please list below)

_____

_____

_____

_____

(**Please Print)**

MEDICATION NAME:	**STRENGTH:**	**HOW MANY TIMES A DAY:**

GENESEE LUNG ASSOCIATES

DR. G. BAYASI, MD DR. M. ABOUDAN, MD DR. M. AL-ALI, MD DR. O. KHORFAN, DO

DR. D. ZAKRI, MD DR. A. WAQAS, MD

PATIENT INFORMATION FORM

PATIENT NAME: _____(MALE/FEMALE) DOB:_____/_____/_____

ADDRESS: _____

CITY: _____STATE_____ZIP_____

PRIMARY PHONE#: _____CELL/WORK #_____

EMAIL: _____ SS#_____

MARITAL STATUS: (CIRCLE ONE) MARRIED SINGLE WIDOW DIVORCED

PRIMARY CARE DOCTOR: _____

CARDIOLOGIST:_____

EMPLOYER: _____PHONE: _____

PRIMARY PHARMACY: _____LOCATION: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE SUBSCRIBER INFORMATION IF DIFFERENT FROM PATIENT

NAME_____ DOB_____

REASON FOR TODAY'S VISIT : _____

PATIENT AUTHORIZATION

I authorize my (or my child's insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Genesee Lung Associates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to Genesee Lung Associates and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account. ***I further agree to pay for any missed appointments of which I didn't contact the medical office within 24 hours.***

_____ DATE_____

(Signature of Patient or Parent/Guardian)

HIPAA AGREEMENT

PRIVACY STATEMENT:

In accordance with the Federal Government policy rules implemented through the Healthcare Portability Act of 1996 (HIPAA). We protect our patient's information and the records that we have about their health and the services received in our office. We ***must*** have your written & signed consent in order to disclose your health information for the purposes of your treatment, the payment of your bills, appointment reminders, etc. I have received a copy of the Privacy Notice. (HIPAA – 164.520) If we refer our patients to another provider or Specialist, we may need to share your medical information with them. Your privacy is protected as only minimum information is shared.

_____ I do ***NOT*** authorize the practice to release any or all information concerning my medical care to any individual except as listed above.

_____ I authorize the practice to verbally release any or all information regarding my medical care to the following individuals. If these individuals call regarding my care, I give my consent for them to be informed of any or all my medical care.

NAME: RELATIONSHIP: PHONE #

_____

_____

_____

_____**DATE**_____

(Signature of Patient)

OFFICE POLICY

We reserve the right to charge for an appointment not canceled without a 24-hour notice.

The fees for an established patient are $25

The fees for a new patient are $50.

To our patients who have Managed Care Insurance (HMO)

All patients requiring a referral **MUST** have a valid referral for each visit. It is the patient's responsibility to make sure a valid referral has been sent to our office prior to visit. If the proper referral hasn't been obtained, the appointment **WILL** have to be canceled.

***** IF YOU DO NOT HAVE THE REFERRAL THE TIME OF YOUR VISIT, AND WE HAVE TO RESCHEDULE YOUR APPOINTMENT, THERE WILL BE A $25 FEE FOR ALL ESTABLISHED PATIENTS. FOR NEW PATIENTS THERE IS A $50 FEE*****

Co-pays are due at the time of your visit

We accept the following payment types:

VISA* MASTERCARD*PERSONAL CHECKS*MONEY ORDERS*CASH

*****THERE IS A $25 FEE FOR RETURNED CHECKS*****

*****THERE IS A $5 ADMINISTRATION FEE ADDED TO YOUR STATEMENT IF YOU FAIL TO PAY YOUR COPAY AT THE TIME OF YOUR VISIT*****

Please be advised that if you are more than 15 minutes late you may be asked to reschedule your appointment. In which the above would apply.

I have read and understand the above policies for Genesee Lung Associates.

Signature _____ Date _____

Name _____ DOB _____

Genesee Lung Associates

Epworth Sleepiness Scale

Directions: Please read the following 8 daytime situations and rate on a scale of 0 to 3, the likelihood of dozing off or falling asleep. Try to answer each question even if you feel it does not pertain to you. Once you are done add your score.

0 = Would never doze **1 = Slight chance of dozing**

2 = Moderate Chance of dozing **3 = High Chance of Dozing**

Situation	Chance of Dozing			
Sitting and Reading	**0**	**1**	**2**	**3**
Watching Television	**0**	**1**	**2**	**3**
Sitting inactive in a public place for example a movie theater or meeting	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Total				