North Point
Pulmonary Associates

3400-C Old Milton Parkway
Suite 425
Alpharetta, GA 30005
Phone: 770-343-8760 Fax: 770-664-2101

1505 Northside Boulevard
Suite 3500
Cumming, GA 30041
Phone: 770-292-3120 Fax: 770-292-3121

Welcome to our practice!

On behalf of North Point Pulmonary Associates, we welcome and thank you for choosing our practice. It is our desire to make your visit a pleasant one and to work with you to establish a positive treatment plan.

Please help us provide the best medical care by bringing the following items:

- **All of your medications**. If you are unable to bring the bottles, please bring a list of medications, the dosage, and the number of times taken daily, including all over-the-counter medications.
- **Previous sleep study records** (If you have had a sleep study previously)
- If you are currently on CPAP or BiPAP, please bring your machine.
- ***Completed*** **History and Demographic forms**
- **Insurance Card**
- **Photo Identification**
- **Insurance Referral from your primary care physician**

We request all History and Demographic documents be completed prior to your appointment and ask that you arrive 30 minutes early. If documents aren't completed, we will need to reschedule your appointment.

Thank you for your assistance and we look forward to meeting you!

Dr. Daniel Callahan
Dr. Eduardo Egea
Dr. Esther Lee
Dr. Simha Jagadeesh
Dr. Sunil Vallurupalli
Dr. Juan C. Cadavid
Dr. S. Arif Mahmood
Michael Rayburn, PA-C
Crystal Kuhn, NP-C
Paul Hwangbo, PA

Patient Name _____ Date of Birth _____

Past Medical History

Please list any medical conditions that you have been diagnosed with:

MEDICAL CONDITION	DATE DIAGNOSED	TREATING PHYSICIAN

Please list any Surgeries and hospitalizations you've ever had.

Surgery	Hospitalization/Reason	Date(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Family History

Please check all that apply:

	MOTHER	FATHER	SIBLING	GRANDPARENT	AUNT/UNCLE
Cancer (Indicate Type)					
Respiratory Disease					
Mental Illness					
High Blood Pressure					
Kidney Disease					
Diabetes					
Heart Disease					
Blood Clot					
Tuberculosis					
Other:					
Other:					

AGE OF DEATH:

Mother _____ Father _____ Siblings _____ Grandparents _____

Social History (please check one)

____ Single ____ Married ____ Divorced ____ Widowed ____ Domestic Partner

Have you ever had x-ray dye? YES/NO **Allergic to x-ray dye?** YES/NO

Have you ever smoked? YES/NO How many packs per day? _____

For how many years? _____ If you no longer smoke, when did you quit?_____

Do you consume alcohol? ____ Currently ____ In the past ____ Never If currently how much? _____

Do you or have you ever used recreational drugs? _____

Do you exercise?_____ **How often?** _____

Have you ever used diet pills? _____ **Medication** _____

Last time taken: _____

Patient Name _____ Date of Birth _____

Are you exposed to any pets? dogs, cats, birds, rodents or wild animals YES/NO

Describe _____

Have you ever worked in/with?

__ MINE __ BRICK PLANT __ FOUNDRY __ QUARRY __ POTTERY __ COTTON/FLAX/HEMP/MILL __ NONE

Have you ever been exposed to?

__ ASBESTOS __ BERYLLIUM __ ACIDS __ LEAD __ SOLVENTS __ COAL DUST __ GRINDING DUST __ NONE

Have you ever served in the military? YES/NO What Branch? _____

Dates of Service? _____

Have you ever lived in any of the following areas? (please circle)

ARIZONA, CALIFORNIA, OHIO VALLEY any other SOUTHERN STATES

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PATIENT HEALTH SUMMARY

Patient Name:	Patient DOB:

VACCINE INFORMATION

Date of last Flu Vaccine: Date of last Pneumonia Vaccine:

ALLERGIES:

DATE (diagnosed)	PAST MEDICAL HISTORY	DATE (surgery date)	PAST SURGICAL HISTORY	STAFF INITIALS

INITALLY COMPLETED BY:

Employee _____ Date _____

_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date
_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date
_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date
_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date	_____ Updated Initial/Date

Review of Systems

Welcome, so that we may provide you with the best care possible, please assist us by completing the following form. Remember — always bring an updated list of all your medications including inhalers.

Please mark all that apply:

GENERAL ☐ NONE
___ Fevers
___ Night Sweats
___ Fatigue
___ Appetite Loss
___ Recent weight Changes

EYES ☐ NONE
___ Glaucoma
___ Cataracts
___ Macular Degeneration

EAR/NOSE/THROAT ☐ NONE
___ Nasal Congestion
___ Postnasal Drip
___ Voice Hoarseness
___ Sinus Disease
___ Seasonal Allergies

CARDIAC ☐ NONE
___ Heart Attack (MI)
___ Valvular Heart Disease
___ Heart Murmur
___ Rheumatic Fever
___ Abnormal Cholesterol
___ Congenital Heart Defect
___ Hypertension
___ Palpitations
___ Heart Rhythm Disorder
___ Pacemaker or Cardiac
___ Defibrillator (ICD)
___ Claudication/Leg Pains
___ Passing out/Syncope

RESPIRATORY ☐ NONE
___ Dry Cough
___ Cough with phlegm
___ Coughing up blood
___ Shortness of breath at rest
___ Shortness of breath with activity
___ Wheezing
___ Chest Tightness

SLEEP ☐ NONE
___ Morning Headaches
___ Excessive Daytime Sleepiness
___ Excessive Snoring
___ Restless Sleep
___ Sleep Disturbance Secondary to Breathing
___ CPAP/BiPAP use

GASTROINTESTINAL ☐ NONE
___ Heartburn/Reflux
___ Difficulty/Painful Swallowing
___ Abdominal Pain
___ Blood in Stool or Vomit
___ Nausea/Vomiting
___ Colostomy/Ileostomy
___ Hepatitis or Jaundice

GENITOURINARY ☐ NONE
___ Painful Urination
___ Frequent Urination
___ Blood in Urine
___ Incontinence/loss of bowel or bladder function
___ Frequent bladder/Kidney infections
___ Enlarged Prostate

GYNECOLOGICAL ☐ NONE
Are you presently or could you be pregnant? Y N
___ Abnormal Mammogram
___ Abnormal Pap smear
___ Hysterectomy

Present or past history of cancer:

Breast Y N
Please describe: _____

Ovarian Y N
Please describe: _____

Uterine Y N
Please describe: _____

MUSCULOSKELETAL: ☐ NONE
Last DEXA: _____
___ Osteoarthritis
___ Osteopenia/Osteoperosis
___ Rheumatoid Arthritis
___ Fibromyalgia
___ Gout
___ Disc Problems
___ Back Pain
___ Trouble Walking
___ Frequent Falls
___ Pain in Legs with Walking
___ Joint Pain (other than arthritis)
___ Bone Pain

NEUROLOGICAL ☐ NONE
___ Fainting Spells
___ Balance Problems
___ Tremors
___ Dizziness
___ Seizures
___ Mini strokes/TIA
___ Stroke
___ Headaches/Migraines
___ Muscle Weakness
___ Memory Problems
___ Difficulty Swallowing
___ History of Polio

BLOOD DISORDERS ☐ NONE
___ Anemia
___ Impaired Immune System
___ Low Platelets
___ Unusual Bleeding
___ Blood Clots (in legs or lungs)

ENDOCRINE ☐ NONE
___ Thyroid Problems
___ Goiter
___ Graves Disease
___ Diabetes

MENTAL/EMOTIONAL ☐ NONE
___ Excessive Stress
___ Anxiety
___ Depression
___ Suicidal Thoughts
___ Sleeping Difficulty
___ Phobias (i.e. claustrophobia)

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MEDICATIONS SUMMARY

Please list ALL current medications below: **Allergies:**

Medication	Strength	Dosage

Pharmacy Information:

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____

NH0670

ADDRESSOGRAPH

NORTHSIDE HOSPITAL

SLEEP DISORDERS CENTER

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Patient Name: _____

Gender (circle one): Male Female Age: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to decide how you would react to these situations. Use the following scale to choose the most appropriate number for each one.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING** (circle one)			
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting, inactive in a public place (e.g., theater or meeting).	0	1	2	3
As a passenger in a car for an hour without a break.	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

TOTAL SCORE: _____ **AVERAGE AMOUNT OF SLEEP PER NIGHT:** _____

SIGN HERE: Completed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

EPWORTH SLEEPINESS SCALE

A Northside Network Provider

English - Spanish

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

Practice Name: _____

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

Federal privacy regulations allow a health care provider, in certain limited circumstances, to discuss your health information, such as details about your care and treatment, with family members and close personal friends who are involved in your care. Depending on the circumstances, health care providers may be prevented from discussing your health information with someone who you might want them to. For that reason, some patients want to specifically authorize healthcare providers to engage in healthcare discussions with certain family members, friends, or other individuals. This form allows you to designate family members, friends or others with whom the practice listed above can communicate about your health care.

By signing below, you understand and acknowledge the following:

- The practice listed above is authorized to engage in discussion about your health care with the individuals listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussions are permitted by law.
- This form permits verbal communication only. This form does not allow the individuals listed below to obtain copies of your medical records.
- This form applies only to the practice listed above. If you receive health care from other Northside affiliated medical practices, you will need to complete a new form for each practice.
- This form is entirely voluntary and optional. Refusing to sign this form will not impact your care provided at this practice.
- Changes to this form must be made in person at the practice listed above.

This form can be revoked by submitting a written request to the Practice Manager of the Northside affiliated physician practice identified at the top of this form. You have the right to revoke this form in writing at any time except to the extent action has already been taken in reliance on it. The consent remains in effect until you revoke it in writing or sign a new form.

First and Last Name	Relationship	Phone Number

_____ _____

Signature of Patient or Legal representative Print name

_____ _____

Date Time Relationship to patient

_____ _____

Interpreter (if applicable) Reason patient unable to sign

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Practice Manager

NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS

A Northside Network Provider

English - Spanish

Name of Patient: _____ Phone #: _____ DOB: _____

Address: _____

Physician Practice Name: _____

The Northside Hospital Office Practice identified above is hereby authorized to (**Please mark appropriate box**):
☐ **Release to OR** ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) (**Please identify by name or general description and provide address, if known**): _____
_____

The following protected health information regarding the patient (**Please mark appropriate box(es)**): ☐ Complete Medical Record
☐ Abstract of Medical Record (physician dictated reports & diagnostic reports) ☐ Labs only ☐ Radiology only ☐ EKG only
☐ Other (**Please specify clearly**) _____

For the following dates of service: Start Date: _____ End Date: _____
In the following format: ☐ Paper ☐ Electronic **Need records certified:** ☐ Yes ☐ No
I understand that in some instances my medical record may also include my health information from other healthcare facilities owned and/or operated by Northside Hospital.

Unless you state otherwise, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse, including drugs and alcohol**, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

Unless you state otherwise by marking one or both boxes below, this authorization **includes** the release and disclosure of records and information which may include (i) **HIV/AIDS** confidential information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and **you affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/AIDS confidential information** is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** confidential information and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I **object** to the release of **HIV/AIDS** confidential information.
☐ I **object** to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is: _____
I understand that my/ the patient's treatment at a Northside Hospital Physician Practice Office and/or Northside Hospital will not be affected if I refuse to sign this authorization. I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. **Note:** This authorization can be revoked by submitting a written request to the **Practice Coordinator at the Northside Hospital Physician Practice Office identified above.**

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:
(a)_____ **(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit)**; **(b)** the date I revoke this authorization in writing; or (c) three (3) years from the date on which I signed this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____
Witness

_____ AM/PM_____
Date Time

_____
Interpreter (if applicable)
Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

_____
Signature of Patient or Legally Authorized Representative, Including Legal Guardian, Health Care Agent, or Parent of Minor Child

Print name: _____

Relationship to patient: _____

Reason patient unable to sign: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

White - Medical Records
Yellow - Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Note: To authorize the disclosure of psychotherapy notes, the additional form entitled ***Authorization for Release of Psychotherapy Notes*** will need to be completed. To authorize the disclosure of patient records from the Northside Hospital Behavioral Health Recovery Program, the additional form entitled ***Authorization for Release of Alcohol and Drug Abuse Patient Records*** will need to be completed.

I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided (including, but not limited to, electronic transmission, paper copies, CDs, films, and flash drives) may be subject to re-disclosure by the recipient and may no longer be subject to protections under the federal privacy laws and regulations. I further understand that any electronic format of my health information that I receive may not be encrypted or password protected and I am responsible for taking precautions to protect the data and storing it in a secure manner. By choosing to receive my health information electronically, I acknowledge and accept the risk of doing so. I hereby release the Northside Hospital Physician Office Practice, Northside Hospital, Inc., and their agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of the medical records and information I have authorized above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse which is protected by Federal confidentiality rules (42 C.F.R. Part 2), the following notice shall also apply.

> **This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**