Long Island Pulmonary and Sleep Medicine Associates PLLC
Louis Saffran MD FCCP ▪ Frank Coletta MD FCCP
Karen Mrejen-Shakin MD FCCP ▪ Michael Megally MD FCCP ▪ Daniel Kurbanov MD FCCP
200 North Village Avenue ▪ Suite 300 ▪ Rockville Centre▪ NY ▪ 11570
Phone (516) 536-8151 Fax (516) 536-8153

PATIENT REGISTRATION AND INFORMATION FORM

LAST NAME:_____FIRST NAME:_____ MIDDLE INITAL:_____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE #:_____

CELL PHONE #:_____

DATE OF BIRTH:_____ SEX:_____ SOCIAL SECURITY #:_____

MARITAL STATUS:_____ SPOUSE NAME:_____ PHONE#:_____

EMAIL:_____

ARE YOU EMPLOYED?_____ IF SO, PLEASE COMPLETE BELOW:

PLACE OF EMPLOYEMENT:_____

ADDRESS:_____

WORK PHONE #:_____

WHO SHOULD WE CONTACT IN AN EMERGENCY?_____

THEIR HOME#:_____THEIR WORK#_____

THEIR CELL PHONE#:_____

PRIMARY CARE PHYSICIAN

Name:_____

Address:_____

Phone:_____

REFERRRING PHYSICIAN

Name:_____

Address:_____

Phone:_____

Pharmacy Name:_____ Address:_____

Pharmacy Phone:_____ Fax_____

SIGNATURE:_____**DATE:**_____

MEDICAL HISTORY

Name:_____ Date:_____

Reason for Consultation: _____

List any Drug Allergies: _____

FAMILY HISTORY

____High Blood Pressure	____Heart Disease	____Epilepsy	
____Diabetes	____Cancer	____Kidney Disease	
____Asthma	____Hay Fever	____Migraine	
____Glaucoma	____Stroke	____Bleeds Easily	
____Mental Illness	____Alcoholism	____Eczema	
____Anemia	____Psoriasis		

YEAR OF IMMUNIZATION

_____Hepatitis	_____Mumps	
_____Pneumonia	_____Rubella	
_____Flu	_____Polio	
_____Tetanus		
_____Diphtheria		
_____Measles		

HOSPITAL ADMISSION Indicate the year you were admitted into the hospital and the reason. Do Not include normal pregnancies.

Year	Illness or Operation	Year	Illness or Operation

MEDICATIONS List all medications that you are currently taking, including over the counter drugs.

Medications	Strength	How Often	medication	Strength	How Often

HAVE YOU EVER SMOKED: ____YES ____NO _____ YEAR QUIT

STILL SMOKING? ____YES ____NO IF YES: Cigarettes Per Day _____ _____# of Years

MEDICAL HISTORY Check all that apply.

__Decreased hearing	**___Blood in stool**	**___Glaucoma**	**___Freq. Urine infections**	**___Numbness/tingling**	**___Asbestosis**
___Ringing in Ear	**___Venereal Disease**	**___Cataracts**	**___Blood in urine**	**___Constipation**	**___Emphysema**
___Freq. Ear infections	**___Hepatitis**	**___Difficulty swallowing**	**___Control of urination**	**___Diverticulitis**	**___Abnormal X-ray**
___Dizzy spells	**___Chest pain**	**___Indigestion/Heartburn**	**___Decreased force in urine**	**___Bronchitis/chronic cough**	**___Pulmonary Fibrosis**
___Measles	**___High blood pressure**	**___Loss of appetite**	**___Kidney Disease**	**___Gall bladder trouble**	**___Narcolepsy**
___Failing vision	**___Swollen ankles**	**___Freq. Nausea/vomiting**	**___Chronic fatigue**	**___Back pain-recurrent**	**___TB**
___Double/blurred vision	**___Moodiness**	**___Peptic ulcers**	**___Recent weight loss**	**___Shortness of breath**	**___Asthma/Wheezing**
___Freq. Eye infections	**___Heart murmur**	**___Chronic abdominal pain**	**___Anemia**	**___Foot pain**	**___Mumps**
___Nose bleeds	**___Irregular pulse**	**___Change in bowel habits**	**___Bruise easily**	**___Cold numb feet**	**___Polio**
___Freq sore throat	**___Palpitations**	**___Diarrhea**	**___Cancer**	**___Rashes**	**___German measles**
___Hay fever	**___Fainting spells**	**___Pneumonia/pleurisy**	**___Thyroid disease**	**___Hives**	**___Rheumatic fever**
___Allergies	**___Kidney stones**	**___Hernia**	**___Diabetes**	**___Difficulty sleeping**	**___Restless Leg Syndrome**
___Hoariness prolonged	**___Leg pain when walking**	**___Arthritis**	**___Convulsions/seizures**	**___Nervousness**	**___Gout**
___freq. headaches	**___Varicose veins**	**___Jaundice**	**___Stroke**	**___Depression**	**___ COPD**
___Hemorrhoids	**___Phlebitis**	**___Bone fracture/joint injury**	**___Tremor/Hands shaking**	**___Memory loss**	**___Sleep Apnea**

ALCOHOL: ____YES ____NO _____ Oz. Per Week Coffee/Tea: YES/NO ____Cups Per Day

Signature:_____ Date_____

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Our staff will need to make a photocopy of the following:

- Insurance Card (front and back)
- Driver's License or picture identification

Primary Insurance

Carrier Name:_____

Policy#:_____Group#:_____

Name of Policy Holder:_____Date of Birth:_____

SSN of Policy:_____Relation to Patient_____

Secondary Insurance

Carrier Name:_____

Policy#:_____Group#_____

Name of Policy Holder:_____Date of Birth:_____

SSN of Policy:_____Relation to Patient_____

Signature:_____Date:_____

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ACKOWLEDGEMENTOF RECEIPT OF
LONG ISLAND PULMONARY AND SLEEP MEDICINE ASSOCIATES, PLLC

I acknowledge that I have received a copy of Long Island Pulmonary and Sleep Medicine Associates, PLLC& Louis Saffran Physician PLLC Notice of Privacy Practices.

Patient Signature:_____ Date:_____

Printed Name:_____

PATIENT CONSENT

I hereby give **Long Island Pulmonary and Sleep Medicine Associates, PLLC & Louis Saffran Physician PLLC** its physicians and staff, my consent to release my protected health information as needed in connection with my care and treatment.

I understand that under HIPAA regulations my consent is not necessary for **Long Island Pulmonary and Sleep Medicine Associates, PLLC & Louis Saffran Physician PLLC** its physicians and staff, to release my protected health information for purposes related to my treatment, payment for my treatment, and healthcare operations.

Patient Signature:_____ Date:_____

Printed Name:_____

MEDICAL CLAIMS INSURANCE
UNDERSTANDING AND CONSENT

I understand and agree to the following:
Should the physician participate with my medical insurance carrier, I am responsible for any and all co-payments, co-insurance, and deductible amounts. I am responsible for all charges incurred should I fail to obtain any necessary referral/ authorization as required by my insurance carrier.

Should the physician not participate with my medical insurance carrier, I am responsible for full payment of all charges incurred.

I consent to the release of any of my protected health information necessary to process medical claims for professional services rendered to me.

Patient Signature:_____ Date:_____

Printed Name:_____

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Long Island Pulmonary and Sleep Medicine Associates, PLLC&/or Louis Saffran Physician PLLC** for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature:_____ Date:_____

Printed Name:_____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize **Long Island Pulmonary and Sleep Medicine Associates, PLLC** to discuss my health information with the following personal representative(s)

Name:	Relationship:	Name:	Relationship:
_____	_____	_____	_____
Name:	Relationship:	Name:	Relationship:
_____	_____	_____	_____

It is the policy of **Long Island Pulmonary and Sleep Medicine Associates, PLLC** to confirm appointment via telephone.

Home Telephone_____ Cell Phone_____

☐OK to leave message with detailed information* ☐Ok to leave message with detailed information*

☐Leave message with call back number only ☐Leave message with call back number only

Written Communication Work Telephone_____

☐OK to mail to my home address ☐Ok to leave message with detailed information*

☐OK to mail to my work/office address(provide address) ☐Leave message with call back number only

☐OK to fax to this number_____

Other:_____

Patient Name:_____DOB:_____

_____ _____
Patient Signature Date

* detailed information may include but is not limited to: lab results, diagnosis and/or treatment instructions.

PLEASE NOTE: THE ABOVE INFORMATION WILL BE IN EFFECT UNTILL YOU REVOKE IT.