FOOTHILL PULMONARY & CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

Patient Personal Information

Name:_____
Address:_____
City/State/Zip:_____
Social Security Number:_____
Date of Birth:____/____/____
Circle Gender: Female Male
Phone (Home): (____)_____
Phone (Work): (____)_____
Phone (Cell): (____)_____
Primary Language:_____
Need Interpreter: (Check One) Yes____ No____
Occupation/Student: _____
Employer/School:_____
Referred By:_____

Responsible Party Information

Name:_____
Address:_____
City/State/Zip:_____
Social Security Number:_____
Date of Birth:____/____/____
Phone (Circle Home/Work/Cell): (____)_____
Relationship to Patient:_____

Emergency Contact

Name:_____
Phone (Home/Work/Cell): (____)_____
Relationship to Patient:_____

Insurance Information

Insurance Carrier:_____
Insurance I.D. #:_____
Type (Circle One) HMO PPO POS Medicare Medi-Cal
Secondary Insurance:_____
Subscriber's Name:_____
Subscriber's Date of Birth:_____

Spouse Information

Name:_____
Address:_____
City/State/Zip:_____
Date of Birth:____/____/____
Phone (Circle Home/Work/Cell): (____)_____
Relationship to Patient:_____
Pharmacy:_____

Authorization

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up lab information, prescriptions, other referral information from Foothill Pulmonary and Critical Care Consultants Medical Group, Inc., and to make and receive phone calls regarding my health and/or the billing related to the service provided to me by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc.

☐ SPOUSE:_____
☐ CAREGIVER:_____
☐ CHILDREN:_____
☐ OTHER:_____

ASSIGNMENT OF BENEFITS

I hereby assign payment of authorized Medicare and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either for me or on my behalf to Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. "I certify that I am eligible for benefits under the pre-paid health benefit plan. In the event I am later found to be ineligible, or as consideration for being treated without proof of eligibility, I agree to pay for any and all services provided by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. at their fees then in effect."

SIGNATURE:_____ DATE:_____

HIPAA PRIVACY POLICY

Our notice of Privacy Practices advises how we may use and disclose protected health information about you. Our current notice is available in our lobby, or upon request. I agree to the uses and disclosures of my information for purposes of treatment, payment, and practice operations.

SIGNATURE:_____ DATE:_____

FOOTHILL PULMONARY & CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____

Name of Patient Date of Birth Signature of Patient/Parent/Guardian Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ Last four digits of his/her SSN (required):_____

Print Name:_____ Last four digits of his/her SSN (required):_____

Print Name:_____ Last four digits of his/her SSN (required):_____

_____

Name of Patient (Print) Signature Date

Witness: _____ Date: _____

◊ 959 E Walnut St., STE 120 | Pasadena, CA 911016 | 626.795.5118
◊ 1818 Verdugo Blvd., STE 207 | Glendale, CA 91208 | 818.790.1730
◊ 301 W Huntington Dr. STE 607 | Arcadia, CA 91007 | 626.445.4558
◊ 101 E Beverly Blvd., STE 307 | Montebello, CA 90640 | 323.888.2548

Foothill Pulmonary and Critical Care Consultants Medical Group INC.

NextGen Patient Portal Authorization

Patient Name: _____

Email (Print): _____

IN EVENT OF AN EMERGENCY, DIAL 911.
Do Not Use the Patient Portal for Urgent or Emergent Matters.

Purpose of this Form
Our Medical Office offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works
A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate
You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal by going to https://nextmd.com/

Protecting Your Private Health Information and Risks
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

Conditions of Participating in the Patient Portal
Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold Foothill Pulmonary and Critical Care Consultants Medical Group INC. or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password. **If you have questions we will gladly provide more information.** *Policies & Procedures are subject to change without notice.*

(Optional) Please allow access to my Patient Portal information to:

_____ _____
Print Name **Relationship**

Patient/Patent/Guardian Acknowledgement

_____ _____
Patient Signature Date

CAIR California Immunization Registry

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, tell your doctor or download a "*Decline or Start Sharing/Information Request Form*" from the CAIR website (http://cairweb.org/cair-forms/) and FAX or email it to the CAIR Help Desk at **1-888-436-8320** or CAIRHelpDesk@cdph.ca.gov.

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

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** By law, public health officials can also look at the registry in the case of a public health emergency.*

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Dear Patient,

In order to serve you, our valued patient, in a more efficient manner, please be advised of the following office policies:

1. Pulmonary Consultation Requirements:

As pulmonary specialists, it is very important that, along with the enclosed history forms, you also bring along all pertinent information. We ask that you bring to your appointment any chest x-ray films and Cat Scans of the chest that have been done within the last 5 years. Please have all relevant x-rays and Cat Scans put on CD-Rom if possible.

Films may be obtained at the radiology group where the x-rays or Cat Scans were originally performed. **PLEASE DO NOT RELY ON FILMS BEING DELIVERED TO OUR OFFICE**. To ensure a complete consultation, please pick up the films and hand-carry them in at the time of your appointment. Please have all relevant x-rays and Cat Scans put on CD-Rom if possible.
If you have any questions or difficulty obtaining your films, please give us a call prior to your appointment so that we may assist you.

2. Medication Refills:

Please have your pharmacy contact our office 3 to 5 days prior to when your medications are expired or completed. Practice good healthy habits and call us with your medication requirements prior to completion of your prescription. This policy allows you to take your medication without any interruptions or compromise in your health and well-being. Routine medication refills (*including all CPAP and BiPAP equipment*) require at least one yearly follow up exam with your physician.

PRESCRIPTION REFILLS ARE NOT PROCESSED ON SATURDAY OR SUNDAY OR AFTER HOURS. Please allow 48 hours for all refills to be processed. Patients *must* be seen within one year for any refills. We are not responsible for your prescription plan coverage. Please read your medical plans pharmacy policies.

3. Laboratory/Diagnostic testing:

All test results are reviewed by the ordering physician within 1 working day of receiving the results. Patients will only be notified of abnormal test results requiring treatment. Patients are always encouraged to contact our office during normal business hours (Monday through Friday 9 a.m. to 5 p.m.) to obtain verbal results from our nurse.

4. Cancelled/Missed Appointments:

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than a 24 hour notice you will be charged a $25.00 fee. Foothill Pulmonary reserves the right to bill the patient according to the scheduled fee or according to the rules of the patient's health plan. You will be billed unless another appointment is made.

5. **Authorization/Eligibility:**

Because of the contractual relationship between Foothill Pulmonary and all managed care insurance plans, I am aware that every visit requires pre-authorization prior to any procedures or lab tests, which may delay health care. Co-payments are expected to be paid at the time of service and are required for each visit.
AUTHORIZATION FORMS MUST BE PRESENTED AT THE TIME OF SERVICE OR YOU MAY BE REFUSED SERVICE OR BE RESPONSIBLE FOR THE BILL AT THE TIME OF SERVICE. I understand I must be seen prior to the expiration date of the authorization, and must be eligible with the insurance at the time of service. I will notify the office of any change in my insurance, primary care physician, or demographic information. Failure to do so may delay the billing process and/or medical care.

6. **Disability forms and other non-insurance forms:**

Due to the complexity of completing certain disability forms and other non-insurance forms, effective August 21, 2008 office has instituted a charge of $35.00 per form to complete these forms. This includes but is not limited to SDI, FMLA, DMV, Electric or Gas Company, jury duty, and airline forms. If you have any questions about this fee, please speak with one of the office staff.

7. **Consent to treat**

The examination you will be receiving is a focused one, for the express purpose of pulmonary or sleep related diagnosis and treatment.

The doctor-patient relationship established by this examination/treatment is limited to this specific purpose. We perform only the examination and care necessary to address this current problem.

Because of this narrowly limited purpose, it is important that we advise you that this examination does not replace your regular medical evaluations done by your personal physician. If you have any other questions of concerns about your health, you must discuss these with your own doctor.

Please be advised, if 3 years have passed since your last visit you will be considered a new patient.

We provide this information because we would like you to be able to plan for your entire health care needs and not inappropriately rely on a limited purpose visit as if it were a comprehensive examination of your overall health. Your ongoing partnership and working relationship with our office and staff allows us to better meet your medical needs. We appreciate, very much, your cooperation and adherence to our policies. We understand the need for personalized medical care and we strive to meet your needs.

Do you have any personal, religious, or cultural preferences which may affect or influence the way you want to be treated?

Yes_____ No_____

If you answered yes, please explain

_____

_____

I agree to allow the physicians of Foothill Pulmonary to render medical care to:

_____
Patient's Name

I have read and understand the above information and agree to all of the terms stated above.
My signature below represents my acceptance of these policies.

_____ _____
Patient's signature Date

ADULT PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____

Name of physician/provider you are seeing today: _____

Medications:
Are you currently taking any medications? ☐ No ☐ Yes
please list medication and dosage if known:

_____

_____

_____

Allergies:
Are you allergic to anything? ☐ No ☐ Yes, please list drug(s) and reaction(s):

_____

_____

Immunizations (approximate dates are fine):

Date of your last flu shot? _____ ☐ None

Date of your last pneumonia shot? _____ ☐ None

Date of your last tetanus shot? _____ ☐ None

Date of your last Hepatitis A shot? _____ ☐ None

Date of your last Hepatitis B shot? _____ ☐ None

Family History (possible genetic illnesses):
Has anyone in your immediate family had any illnesses, such as, heart disease, cancer, diabetes, etc ☐ No ☐ Yes, please list which family member and illness?

_____

_____

Social History:

Occupation: _____ Employer: _____ ☐ Retired

Are there any occupational hazards at your place of employment such as: asbestos, chemical, excessive noise, potentially toxic fumes? ☐ No ☐ Yes, Please list:

_____

Do you smoke? ☐ No ☐ Yes, please list quantity: _____

Do you drink alcohol? ☐ No ☐ Yes, please list quantity: _____

Do you drink caffeine? ☐ No ☐ Yes, please list quantity: _____

Do you use any illicit drugs? ☐ No ☐ Yes, please list quantity: _____

Pt Name: _____ Date: _____

PULMONARY HISTORY

Shortness of Breath

	Please Check Yes	No
1. Are you troubled by shortness of breath when		
a. Walking on level ground or up a slight hill?	☐	☐
b. Walking with other people of your own age on level ground?	☐	☐
c. Resting (not exercising)?	☐	☐
d. Performing your daily activities such as dressing, bathing, undressing, or eating?	☐	☐
2. How far can you walk before stopping due to shortness of breath?		
a. Number of blocks _____		
b. Number of stairs _____		
3. When did you first notice shortness of breath? _____		
4. Has your shortness of breath increased since that time?	☐	☐
5. What type of regular exercise do you perform? _____		

Wheezing

1. Does your chest ever sound wheezy or whistling?	☐	☐
a. ☐ when you have a cold		
b. ☐ occasionally		
c. ☐ most days or nights		
d. ☐ with exercise		
2. For how many years has this been present? _____		
3. Have you ever had an attack of wheezing that has made you feel short of breath?	☐	☐
4. How old were you when you had your first attack? _____		
5. Have you had 2 or more episodes?	☐	☐
6. Have you ever required medicine or treatment for the(se) attacks?	☐	☐

Sputum

1. Do you usually bring up sputum (mucus or phlegm) when you cough?	☐	☐
2. How often do you bring up sputum?		
a. ☐ usually		
b. ☐ intermittently		
c. ☐ never		
d. ☐ only at night or upon arising		

Sputum

	Please Check Yes	No
3. Do you usually bring up sputum (mucus or phlegm) when you cough?	☐	☐
4. How often do you bring up sputum?		
a. ☐ usually		
b. ☐ intermittently		
c. ☐ never		
d. ☐ only at night or upon arising		
5. For how many years have you produced sputum? _____		
6. What is the usual color of your sputum? _____		
7. How much do you cough up in a 24-hour pd?		
a. ☐ less than 1 TBS		
b. ☐ more than 1 TBS		
c. ☐ more than 1 cup.		
8. Have you noticed an increase in the amount of sputum?	☐	☐

Cough

1. Do you cough?	☐	☐
a. when? _____		
b. is it ☐ productive or ☐ dry?		
2. How long have you had this cough? _____		
3. Have you noticed a change in your coughing over the last year/ six months?	☐	☐
4. Have you ever coughed up blood?	☐	☐

Sinuses

1. Do you have trouble with your sinuses?	☐	☐
2. Do you have postnasal drip?	☐	☐
3. Do you have trouble with a runny nose?	☐	☐

Chest Illnesses

1. If you get a cold does it usually go to your chest?	☐	☐
2. During the past 3 years, have you had any chest illnesses that have kept you home from work in bed?	☐	☐
3. Did you produce sputum with these colds?	☐	☐
4. In the last 3 years, how many chest illnesses, with increased sputum did you have which lasted a week or more?	☐	☐
5. Did you have any lung trouble before the age of 16?	☐	☐

Pt Name: _____ Date: _____

Chest Illnesses

Please Check

		Yes	No
6.	Have you ever had any of the following? *Confirmed by a doctor*		
a.	attacks of bronchitis	☐	☐
b.	pneumonia	☐	☐
c.	hay fever	☐	☐
d.	chronic bronchitis	☐	☐
e.	emphysema	☐	☐
f.	asthma	☐	☐
g.	tuberculosis	☐	☐

		Yes	No	Age
a.	attacks of bronchitis	___	___	___
b.	pneumonia	___	___	___
c.	hay fever	___	___	___
d.	chronic bronchitis	___	___	___
e.	emphysema	___	___	___
f.	asthma	___	___	___
g.	tuberculosis	___	___	___

7. Have you ever had any other chest illnesses? If yes please specify.

_____

_____

_____

_____

Heart Function

		Yes	No
1.	Have you ever had		
a.	chest discomfort?	☐	☐
1.	at rest	☐	☐
2.	with exercise	☐	☐
b.	irregular heartbeat or murmurs?	☐	☐
c.	swelling of your feet or ankles?	☐	☐
d.	shortness of breath at night?	☐	☐
2.	Do you		
a.	sleep sitting up?	☐	☐
b.	sleep on more than one pillow?	☐	☐

Risk Factors

		Self	Family Member
1.	Have you or any member of your family ever had:		
a.	hay fever	___	___
b.	eczema	___	___
c.	hives	___	___
d.	asthma	___	___
e.	aspirin intolerance	___	___
f.	Nasal polyps	___	___
g.	Sinus infections	___	___
h.	Tuberculosis	___	___
i.	Valley fever	___	___
j.	Cystic fibrosis	___	___
k.	Emphysema	___	___

Risk Factors

Please Check

		Yes	No
2.	Do you have any allergies? If yes, please list.	☐	☐
	_____		
	_____		
	_____		
3.	Have you ever had		
a.	anesthesia?	☐	☐
b.	chest surgery? (please specify) _____	☐	☐
c.	chest trauma/injury? (please specify) _____	☐	☐
4.	Have you had any recent		
a.	weight loss or gain	☐	☐
b.	fever, chills or sweats?	☐	☐
c.	loss of appetite?	☐	☐

Sleep Disturbances

		Yes	No
1.	In which position do you sleep? _____ Why? _____		
2.	Do you frequently		
a.	awaken at night?	☐	☐
b.	have nightmares?	☐	☐
c.	wake up in the morning with a headache?	☐	☐
3.	Have you ever been told that you snore heavily or stop breathing while you are sleeping?	☐	☐
4.	Do you have difficulty staying awake during the day?	☐	☐

Smoking History

For present or former smokers only

		Yes	No
1.	Do you smoke cigarettes?	☐	☐
a.	☐ with filters		
b.	☐ without filters		
c.	☐ smoke both		
2.	Do/did you inhale?	☐	☐
3.	How many cigarettes do/did you usually smoke? _____		
4.	In past years, did you usually smoke more cigarettes than you do at present?	☐	☐
5.	If yes, what was the usual number you smoked then? _____		
6.	How many total years have you smoked? _____		

Pt Name: _____ Date: _____

Review of Systems

	Yes	No
Breasts		
1. Have you had any surgery on your breasts?	☐	☐
2. Do you have any		
a. breast lumps?	☐	☐
b. nipple discharge?	☐	☐
Gastrointestinal		
1. Have you ever had		
a. an ulcer?	☐	☐
b. liver disease?	☐	☐
c. pancreatic disease?	☐	☐
d. gallbladder disease?	☐	☐
e. diabetes?	☐	☐
Genitourinary		
1. Do you have		
a. kidney problems?	☐	☐
b. burning on urination?	☐	☐
c. difficulty emptying bladder?	☐	☐
Male		
Prostate problems?	☐	☐
Female		
Menstrual problems?	☐	☐
Age at menopause	_____	
Date of last pelvic	_____	
Number of pregnancies	_____	
Number of live births	_____	
Number of miscarriages	_____	

	Yes	No
Muscoloskeletal		
1. Do you have		
a. arthritis?	☐	☐
b. joint pain?	☐	☐
c. joint swelling?	☐	☐
d. joint redness?	☐	☐
Endocrine		
1. Do you have		
a. anemia?	☐	☐
b. polycythemia?	☐	☐
c. bleeding tendency?	☐	☐
2. Have you ever had a transfusion?	☐	☐
3. Do you have		
a. thyroid disease?	☐	☐
b. adrenal disease?	☐	☐
c. pancreatic disease?	☐	☐
d. any lymph gland disorder?	☐	☐
Psychiatric		
1. Have you ever had		
a. serious psychiatric problems?	☐	☐
2. Do you suffer from		
a. depression?	☐	☐
b. anxiety?	☐	☐

Social History

Birthplace:

_____

Alcohol Consumption:

_____

Past Medical History

Allergies:

_____

_____

_____

Previous Surgery:

_____

_____

_____

Major Trauma:

_____

_____

_____

Medical Illness:

_____

_____

_____

Pt Name: _____ Date: _____

Family History

	Yes	No
What is the health of:		
Mother: _____		
Father: _____		
Siblings: _____		
_____		
Is there a tendency for:		
Diabetes?	☐	☐
High Blood Pressure?	☐	☐
Cancer?	☐	☐
Bleeding?	☐	☐
Heart Disease?	☐	☐

Occupational History

1. What is your present employment status?
   - ☐ Full Time
   - ☐ Part Time
   - ☐ Student
   - ☐ Unemployed
   - ☐ Retired for health reasons
   - ☐ Retired

2. Have you ever been exposed to or work at a job or hobby with the following materials: (Please Circle)

1)	aerosols	15)	lead
2)	anesthetic gases	16)	mercury
3)	asbestos	17)	paints
4)	asphalt and tar	18)	pesticides/ fungicides
5)	beryllium	19)	plastics
6)	coal	20)	powders
7)	cotton	21)	silicates
8)	creosote	22)	solvents
9)	crop dust and sprays	23)	tobacco leaves
		24)	welding fumes
10)	dusts	25)	x-ray, radioactive or nuclear materials
11)	dyes and stains		
12)	fiberglass	26)	chemicals
13)	fluorescent lights	27)	gases
14)	gasoline and oils		

3. Have you ever worked in any of the following industries or occupations? Please include jobs while in school, part-time jobs, and jobs in the military services: (Please Circle)

1)	auto repair	15)	mining
2)	brake lining	16)	office worker
3)	carpentry	17)	operating room
4)	chemicals	18)	painter
5)	construction	19)	pipe fitter
6)	demolition	20)	plastics
7)	digging	21)	painter
8)	dry cleaning	22)	sawmill
9)	electronics	23)	shipyards
10)	farming	24)	welding
11)	foundry	25)	petroleum
12)	hairdresser	26)	sandblaster
13)	cotton ginner	27)	textiles
14)	grain elevator (silo)	28)	steel mill

Occupational History

	Yes	No
4. Have you ever worked at any other dusty job? Please specify. _____	☐	☐
5. Have you ever worked at a job in which you noticed changes in your breathing ability (increases in shortness of breath, coughing, sneezing, chest colds)? Please specify. _____	☐	☐
6. Have you ever changed occupations because of a health problem at work? Please specify. _____	☐	☐
7. Have you had any health problems connected with your current job? Please specify. _____	☐	☐

Environmental

1. Have you ever changed your location and residence because of a breathing problem? Please specify. _____	☐	☐
2. Do you presently live near a freeway or industry?	☐	☐
3. Do you have any pets? ☐ dog ☐ cat ☐ bird ☐ other _____	☐	☐
4. Do you use aerosols at home?	☐	☐
5. What type of heating do you have? _____		
6. Do you have a space heater?	☐	☐
7. Do you have air conditioner?	☐	☐
8. Do you have a fireplace? Type: _____	☐	☐
9. Have you traveled within the U.S. in the past year?	☐	☐
Have you traveled outside the U.S. in the past year?	☐	☐

FOOTHILL PULMONARY AND CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

301 W. Huntington Dr., Suite 607
Arcadia, California 91007
(626) 445-4558

959 E. Walnut St., Suite 120
Pasadena, California 91107
(626) 795-5118

1818 Verdugo Blvd., Suite 207
Glendale, California 91208
(818) 790-1730

101 E. Beverly Blvd., Suite 307
Montebello, California 90640
(323) 888-2548

Authorization to Release Protected Health Information

HIPPA Compliant Request for Information

Name of Patient _____ Street Address _____

Phone Number _____ Fax Number _____ City _____ State _____ Zip Code _____

Email Address (please be sure to print clearly) _____ Date of Birth (00/00/0000) _____ Last Four Digits of SSN _____

I hereby give the following person(s) or entity to release my protected Health Information (PHI):

Please choose the method of delivery by checking the preferred option and filling in the information where required. Be certain that information is accurate and complete. **Incomplete authorizations are invalid.**

_____ U.S. Mail to my personal address.
(Records will be mailed to address listed above)

_____ I prefer to pick up my records personally. Please call me when they are ready.
(Photo ID will be required for pick up)

____ Please send my records to the following

_____
Name of medical office/Company/Entity you want to receive the records.

_____
Street Address

_____
City State Zip Code

(___)_____(___)_____
Phone Number Fax Number

The protected Health Information (PHI) I would like to have released is as follows:

___ Release an abstract of my PHI (two (2) year summary)

___ Release my entire chart (subject to state regulated per page fees)
(You will receive an invoice. Records are not released until invoice is paid in full)

___ I would like specific dates of service_____

Please provide the purpose of your request _____

This authorization shall expire ninety (90) days from the date of signature, or at the following event: _____

I am requesting my PHI to be disclosed for the following reason: _____

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the health care provider at which this authorization was executed. Such revocation will be effect upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request.
The recipient of this protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law. I understand that this authorization will expire in 90 days from the date of my signature. I hereby acknowledge that I have read and fully understand the above statements that apply to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Personal Representative (attach proper document) Date