Ahmed A. Fadil, M.D.
Internal Medicine, Pulmonary, Critical Care and Sleep Medicine

PATIENTS DEMOGRAPHICS

Date: _____

First Name _____ MI ____ Last Name _____

Sex: M or F (Circle one) Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____

Work Telephone: _____

Cell/Pager No: _____

Date of Birth: _____ Single: _____ Married: _____

Social Security No: _____

Occupation_____

Primary Insurance: _____

Insured Name: _____ Insured Date of Birth: _____

Policy I.D No: _____

Secondary Insurance: _____

Insured Name: _____ Insured Date of Birth: _____

Policy I.D No: _____

Primary Doctor: _____
Address: _____

Referring Doctor: _____

Address: _____

Reason for Visit: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practice (NPP). This notice describes how your medical information maybe used and disclosed by us. It also tells how you can obtain access to this information.

As a patient; you have the following rights:

1. **The right to inspect and copy your information.**
2. **The right to request corrections to you information.**
3. **The right to request you information be restricted.**
4. **The right to request confidential communications.**
5. **The right to have a copy of this notice.**

We wanted to assure you that you medical/health information is secure with us. This notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES **I hereby acknowledge my rights. I understand that if I have any questions or complaints regarding my privacy rights that I should contact the office manager.**
Patient name [please print]
Patient please sign and date

NO SHOW POLICY

Our office strives to provide you with high quality care and patient satisfaction. We are dedicated and devoted to making you feel right at home and accommodate you with all your needs. In order to be productive in our work, we must work together.

Cancellations are to be made 24 hours prior to your date of service. If you do not show on your scheduled date of appointment, there will be a penalty charge. Charges are as follows:

- Follow Up: $ 50.00
- Pulmonary Function Tests: $ 100.00
- Sleep Studies: $ 100.00

Our office has a very supportive team of Medical Assistants, Sleep Technicians, and Respiratory Therapist that are here to provide services to you. We require **MANDATORY** notification of any cancellations.

_____
Print Full Name

_____ _____
Signature Date

NORTHEAST INSOMNIA & SLEEP MEDICINE

1855 Richmond Ave
Staten Island, NY 10314
T: 718-761-2950 F: 718-761-2970

To All Patients:

If you have an IN network deductible that has not yet been met, you will be required to pay for your deductible.

Signature Date

MEDICATION LOG

Patient____ **Birth date** ___________________ **Age** _____________

Pharmacy ____ **Pharmacy Phone** __________________________

Date Rx	Medication	Dosage	Quantity	Frequency

Medical History Questionnaire

Patients Name _____ **Date** _____

Reason for Visit _____
_____
_____

Please check the signs and symptoms you currently have or have had in the past year.

General

	Chills		**Depression**
	Nervousness		**Dizziness**
	Fever		**Forgetfulness**
	Headaches		**Loss of sleep**
	Lost of weight		**Numbness**
	Sweats		**Fainting**
	Shortness of breath		**Chest congestion**
	Chronic cough		**Productive cough**
	Wheezing		**Chest pain**
	Sinus Problems		**Blurred vision**

Muscle/Joint/ Bone

Pain, numbness or weakness

	Arms		**Hips**
	Back		**Legs**
	Feet		**Neck**
	Hands		**Shoulders**

Check the conditions you have had in the past

	Asthma		**Multiple sclerosis**
	Cancer		**Pacemaker**
	Emphysema		**Pneumonia**
	Diabetes		**Tuberculosis**
	Bleeding disorders		**Thyroid problems**
	Heart disease		**Stroke**
	Hepatitis		**Ulcers**
	Kidney disease		**Chemical dependency**
	Liver disease		**Arthritis**

Have you been treated for any of these symptoms or conditions marked above?

Circle one: **yes** **or** **no**

Who treated you _____