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Hemant M. Shah, MD, FACP, FCCP
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Salman S. Razi, MD
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Keren Ray, DO
Keren Ray, DO
Jose U. Torres, DO
Gnanam Thambipillai, MD
Michele Evanson, DO
Anne Reddington, DO

Welcome to Pulmonary Medicine of Dayton, Inc. We look forward to serving you. Kindly fill out the enclosed paperwork and bring it with you to your appointment.

1. Please give as much detail as possible on the information sheets.
2. Please have your family physician give you copies of any testing that you have had that relate to your pulmonary problems. (Your doctor can also fax these to us at 937-439-3786.)
3. You must bring your insurance card or cards with you. Also, if your insurance requires a referral, you must have it faxed to our office before your appointment.
4. Your co-payment will be due at the time of service. We accept cash, personal checks, MasterCard and Visa.
5. You **MUST** bring your chest X-ray and/or CAT scan with you to your appointment. These cannot be faxed. A current X-ray (done within the last 12 months) and an older one (if available) for comparison. These can be actual films or on a CD; either format is acceptable.

Please call at least 24 hours in advance to cancel any appointment. You may be charged a \$20.00 fee for a no call/no show office visit. This courtesy will allow another patient the opportunity to be seen sooner.

Our main office:

Interstate Executive Center
6728 Loop RD, Suite 101 (building 5)
Centerville, OH 45459

Our satellite office:

Kettering Medical Center
Physicians' Office Building
3533 Southern Blvd, Ste 5800
Kettering, OH 45429

Please call us if you have any questions regarding your appointment (937) 439-3600.

We look forward to meeting you!

**PULMONARY MEDICINE
OF DAYTON, INC.
PATIENT INFORMATION**

PLEASE PRINT CLEARLY

DATE: _____

PATIENT NAME: _____ BIRTHDATE: _____ AGE: _____ SEX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____ MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

OCCUPATION: _____ EMPLOYED BY: _____

WORK PHONE NUMBER: () _____ SOCIAL SECURITY NO: _____

CELL PHONE NUMBER: () _____ E-MAIL ADDRESS: _____

SPOUSE'S NAME: _____ BIRTHDATE: _____

OCCUPATION: _____ EMPLOYED BY: _____

WORK PHONE NUMBER: () _____ SOCIAL SECURITY NUMBER: _____

PRIMARY INSURANCE: _____ POLICYHOLDER NAME: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

SECOND INSURANCE: _____ POLICYHOLDER NAME: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

REF. / FAMILY PHYSICIAN: _____

ADDRESS: _____ PHONE: () _____

PERSON TO CONTACT IN AN EMERGENCY: _____

RELATIONSHIP: _____ PHONE: () _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **PULMONARY MEDICINE OF DAYTON, INC.**

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 charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure the payment.**

SIGNED: _____ DATE: _____

Felipe A. Rubio, MD
Hemant M. Shah, MD
Mariano M. Iberico, MD
Salman S. Razi, MD
Median Ali, MD

Name: _____

DOB: _____

Home # _____ **Work #** _____

Referring physician: _____ **phone:** _____

Family physician: _____ **phone:** _____

Other physicians: _____ **phone:** _____

Why are you seeing the lung doctor? (please describe your symptoms)

_____ Abnormal
Chest X-Ray/CatScan _____

CURRENT PROBLEMS:

Cough _____ Onset _____

Clear / Green / Yellow (thick / thin / Sticky) _____

Coughing up blood _____ Amount (TSP / TBSP/ Streaks) _____

Shortness of Breath (with or without activity) _____

Chest heaviness / Pressure / Tightness _____

Do you Snore (heavy / Light) _____

Wheezing (all the time / with activity) _____

Weight Loss (how much / over how long) _____

Headaches _____

Nasal Drainage (clear/green/yellow) _____

Fevers _____

Hoarseness in voice _____

Gagging or Choking when eating or drinking _____

Other _____

Do you have Allergies: (list them) "What Happens"

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Appointment Date: _____
Name: _____
DOB: _____

Have you had the following done?

Breathing Test (when/where) _____ Chest x-ray (when) _____
CAT SCAN (when) _____ Cardiac Stress test (when) _____
Heart Catheterization (when) _____ 2-D Echocardiogram (when) _____
Pneumonia Vaccine (when) _____ Flu Vaccine (when) _____
Tuberculosis Exposure (when) _____ Last Skin test (positive/negative) _____

Past Medical Problems: (circle)

High Blood Pressure Pneumonia COPD/Emphysema
Heart Disease Asthma Diabetes
Cancer (when/where) _____ Other _____

Surgeries or Hospitalizations (Please List)

Family History: List any health problems

Father: (Living /Deceased) _____
Mother: (Living / Deceased) _____
Brothers/Sisters: (Living /Deceased) _____
Children (Living / Deceased) _____

Habits: Do you do any of the following?

Smoke Cigarettes/ Cigars How many a day _____ How many years _____ Quit, when _____
Chew Tobacco _____ Use any other Drugs _____
Alcohol: Type / How much a day or week? _____

Occupation/ Retired/ Disabled _____

Occupational Exposure:

(Asbestos, Chemicals, Fumes, Dust, Fibers, Metals, Radiation)
Coal Miner, Welder, Factory, Farmer, Grinder:

Pets: (inside/outside) / Any Birds? _____
Blood Transfusion (when /why) _____

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 Median Ali, MD

Appointment Date: _____
 Name: _____
 DOB: _____

Please circle any of the following that you have recently experienced.

| | | | | | | |
|------------------------|----------------------|-------------------------|------------------------|---------------------------|------------------------|--------------------|
| Constitution: | Fever | Fatigue | Chills | Night Sweats | Weight Loss | Weight Gain |
| Cardiovascular: | Chest Pain | Palpitations | Swelling (edema) | Murmurs | | |
| Eyes: | Blurred Vision | Loss of Vision | Double Vision | Glaucoma | Watery Eyes | |
| Ears, Nose, and Throat | Hearing Loss or Pain | Ringing in ears | Nasal Obstruction | Hoarseness or Sore Throat | Bleeding Gums | Dentures |
| Allergy/Immunology: | Runny Nose | Sneezing | Allergic reactions | Bloody Nose | Hives | Localized Rash |
| Hematology/Lymph: | Easy Bruising | Bleeding Tendency | Enlarged Lymph Nodes | | | |
| Neurology: | Headaches | Seizures | Coordination Problems | Dizziness | | |
| Skin: | Rash | Itching | Dry Skin | Unusual Moles | Breast Lumps | Skin Sores |
| Musculoskeletal: | Joint Pain | Joint Swelling | Weakness | Back Pain | | |
| Psychiatric: | Feeling Anxious | Feeling Depressed | Feeling Sad | Thinking of Suicide | | |
| Gastrointestinal: | Heartburn | Nausea Vomiting | Diarrhea! Constipation | Abdominal Pain | Trouble Swallowing | Changes in Stool — |
| Endocrine: | Excessive Thirst | Excessive Urination | Heat Tolerance | Cold Intolerance | | |
| Genitourinary: | Frequent Urination | Loss of Bladder control | Difficult Urination | Painful urination | Changes in Urine color | |

Pulmonary Medicine of Dayton Privacy Practices

The staff of Pulmonary Medicine of Dayton, Inc. will not directly use or allow the use of Pulmonary Medicine of Dayton data for any purpose other than that directly associated with any official assigned duties. We understand that all patient's information including financial data will be held strictly confidential. Official HIPAA manual is available for your review.

You have my permission to discuss my medical record information and account with the following individuals:

| Name | Relationship | Phone |
|-------|--------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I have received Pulmonary Medicine of Dayton, Inc.'s Notice of Privacy Practices.

Name (Please Print): _____

Signature: _____

Witness: _____

Pulmonary Medicine of Dayton, Inc.
6728 Loop Road, Suite 304
Centerville, OH 45459
Phone: (937) 439-3600 Fax: (937) 439-3786

Pulmonary & Critical Care Medicine
Felipe A. Rubio, M.D.
Hemant M. Shah, M.D.
Mariano M. Iberico, M.D.
Salman S. Razi, M.D.
Median Ali, M.D.

Internal Medicine
Ivo C. Seni, M.D.
Patrick U. Mezu, M.D.
Keren Ray, D.O.
Edgar R. Santillan, M.D.
Jose Torres, M.D.
Michele L. Evanson, D.O.
Gnanam Thambipillai, M.D.
Anne Reddington, D.O.

Authorization For Transfer of Medical Records

Expires: _____

Patient's Name: _____

Address: _____

City, State, ZIP Code: _____ Telephone: _____

Date of Birth: _____ Social Security #: _____ - _____ - _____

I hereby authorize _____ to transfer my medical records and any other medical information necessary for the purpose of continuing medical care and/or _____. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug and alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions. Records to be released to:

Information Requested

- History/Physical
- Physician's Letters
- Pulmonary Function Tests
- EKG Interpretations
- Skin Testing/PPD
- Copies of **Entire Record**

- X-Ray Reports/CT Scans
- Other-Please Specify: _____

I understand that I am responsible for its content and will in no way hold the above responsible for the disclosure of information revealed in my medical records. I acknowledge the right to revoke this authorization in writing according to Pulmonary Medicine of Dayton, Inc.'s Notice of Privacy Practices.

Patient Signature _____

Staff Member Completing Authorization _____

Today's Date _____

Pulmonary Medicine of Dayton, Inc

Our Main Office:

6728 Loop Road, suite 304

Centerville, Ohio 45459

WE ARE BUILDING #5

From the South (Franklin, Springboro, Middletown)

Take I-675 North to Exit 4B- this will wrap around and you will end up on Route 48. At the 2nd Traffic Light you will make a Right onto Loop Road (There are car lots on the corner) Pass all of the car lots, over the bridge and on the LEFT side of street (VERSAILES) Turn LEFT and then a Quick RIGHT into the parking lot. Build 5 is on the left. **The clinic where you will see the doctor is suite 101, on the first floor.**

From the North (Fairborn, Xenia, Beavercreek)

Take I-675 South to Exit 4 (Route 48) at the end of the exit ramp turn RIGHT. At the first light will be LOOP ROAD (RIGHT). Then pass all of the car lots, over the bridge and you will see a side street (VERSAILES) turn LEFT and then a quick RIGHT into the parking lot. Building 5 in on the left. **The clinic where you will see the doctor is suite 101, on the first floor.**

Our Satellite Office: 3533 Southern Blvd Kettering Hospital #5800

From the North (Fairborn, Xenia, Beavercreek)

I-675 South toward Indian Ripple Road (exit 10) Turn RIGHT at the end of ramp. You are on Indian Ripple and Dorothy Lane. Follow the road approximately 4.4miles. Southern Blvd. Turn LEFT. Go down Southern Blvd and you will see the Hospital- Turn in the Driveway that states Physician's Office building/Parking Garage. Go to the Stop sign go (straight) you will be at the side of the building. Park and go in the doors the elevators are on the RIGHT. (Suite #5800 / Fifth Floor)

From South (Franklin, Miamisburg, Springboro)

I-75 North (Exit 47) Moraine/Kettering, Merge on to South Dixie Highway approx. 0.4 miles, South Dixie Drive 0.6 miles. Turn RIGHT on to Stroop Road 0.9 miles. Then LEFT onto Southern Blvd. Go down Southern Blvd and you will see the Hospital- Turn in the Driveway that states Physician's Office building/Parking Garage. Go to the Stop sign go (straight) you will be at the side of the building. Park and go in the doors the elevators are on the RIGHT. (Suite #5800 / Fifth Floor)