TRIKA MEDICAL INC.

BREATHE RIGHT, SLEEP THROUGH THE NIGHT

Dr. Anurag Sahai, MD, FCCP, FAASM

18095 HWY 18, STE B, Apple Valley Ca 92307, United States

Tele: 760-242-2333

Fax:7 60-242-2337

Patient:_____ Date of Birth:_____ Male/Female

Mailing/Home Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

SSN:_____ Email:_____

Race:_____ Ethnicity:_____ Language:_____

Spouse/Emergency Contact - Name:_____ Relationship:_____

Phone:_____ Address (if different from above):_____

Next of Kin:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

Primary Insurance:_____ ID # :_____

Secondary Insurance:_____ ID # :_____

Please read and sign ALL of the following statements:

Please Note: If you are Private Pay. Payment is required when services are rendered! Please remember that we bill your health insurance as a courtesy for services provided. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with insurer) IN ORDER TO HELP CONTROL THE COST OF BILLING, WE REQUEST PAYMENT BE MADE FOR ALL OFFICE SERVICES AT THE TIME OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I authorize that payment of benefits be made on my behalf to Trika Medical Inc for any services furnished to me in Medicare assigned cases the physician agrees to accept the charge determination as the full change and it is the patient's responsibility only for deductible, co-insurance, and non-covered services.

Signature:_____ Date:_____

Consent to treat. The undersigned consents to treatment which may include, treatment performed on outpatient basis, emergency treatment, laboratory procedures, radiology, medical or surgical treatment or procedures under special instructions of the physician or surgeon.

Signature:_____ Date:_____

Insurance Authorization and assignment: 1 authorize Trika Medical to furnish information to insurance carriers concerning my illness. I hereby assign Trika Medical Inc, all payments for medical services rendered to myself.
I understand that I am responsible for the amount not covered by my insurance company.
You are liable for $50 inconvenience fee if you do not provide a 24 hour notice for cancellation or if you do not show to your appointment. There will be a $300 fee for na show to sleep study appointments

Signature:_____ Date:_____

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Pharmacy Name & location: _____

Medication	Dosage	Directions

Inhalers- (name, dosage, directions)

Nebulizers- (name, dosage, directions)

Oxygen- (24/7, as needed, at night) liter flow _____ Provider _____

Cpap/Bipap- Provider _____ Pressure setting _____

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Patient History Questionnaire

Patient Name:_____ Primary Care Physician:_____

Social Security # :_____ Date of Birth: _____ Sex: M / F

Past Medical Problems:

Place an X below if you ever had any of the following medical problems. Please be specific

---Pneumonia	---Sleep Disorder	---Any Cancer (Specify)
---Tuberculosis	---High Blood Pressure /Cholesterol	---Allergies
---Emphysema, COPD	---Irregular heart rhythm	---Rheumatic/Scarlet Fever
---Pleural Effusion	---Stroke	---Ulcer/ Stomach Disorder
---Lung Cancer Nodule	---Ångina/Heart Disease	---Kidney Stones
---Asthma	---Diabetes	---Urinary Tract infection
---Other lung Problems	---Jaundice/Luver Problems/Hepatitis	---Sexualty Transmitted Disease
---Restless Legs	---Thyroid Disease	---Seizures
---Sleep Apnea	---Anemia/Blood Disorder	---Other Specify

Past Surgeries and Hospitalization:

Procedure	Date	Hospital

Allergies to medications: (List or write none) _____

Family History:** Please list any family members, their age and any medical problems. Please include Parents, Siblings and Children (deceased family members as well) THIS SECTION IS IMPORTANT AND MUST BE COMPLETED. (Example- Cancer, diabetes, high blood pressure, high cholesterol, etc.)

_____

_____

_____

ALCOHOL / SUPPLEMENTS: Do/Did you smoke? Yes / No Quit: ___ /___ /___ If yes, what do you smoke?
Cigarettes / Cigars Pipes How many years did you smoke?
How many cigarettes cigars / pipes do/did you smoke per day?
Do you use smokeless tobacco? Yes / No Quit: ___ /___ /___
Yes No Quit Do you consume alcoholic beverages? Yes/No How many?___Quit___ /___ /___
Cups per day Soda___ Tea___ Coffee___ Recreational Drugs (specify)_____

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Patient History Questionnaire II

Patient Name: _____ Date of Birth: _____

Lungs:

Cough-Yes/No If yes, how long? _____

Phlegm-Yes/No If yes, what color? _____

Blood in Phlegm- Yes/No If yes, how long? _____

Shortness of Breath-Yes/No If yes, how long? _____

How far can you walk on level ground without getting short of breath?

_____

Do you feel any difference in breathing while standing sitting up or laying down? _____

Do you have a runny nose, stuffy nose or post nasal drip? (Please circle): _____

Do you haye any heartburn/acid reflux? if yes,
How long? _____

Do you have any chest pain? If yes, How long? _____

Do you have any swelling in your feet? _____

Any significant weight loss or weight gain? How much? _____

Sleep:

Are sleepy in the daytime? _____

Do you snore? _____

Do you wake up with a headache? _____

Do you have dryness of mouth when you wake up? _____

Do you have difficulty falling asleep? _____

Do you walk or talk in your sleep? _____