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

Name: _____ **Date of Birth**: _____ **Female/Male?**

Postal address/home address: _____ **ZIP**: _____

Home Phone _____ **Cell Phone:** _____

Social Security number: _____ **Email:** _____

Race: _____ **Ethnicity**: _____ **Language:** _____

Emergency contact: _____

Telephone: _____ **Telephone:** _____ **Next of Kin:** _____

Telephone: _____ **Telephone**: _____ **Address:** _____

Primary Insurance: _____ ID: _____

Secondary Insurance: _____ ID: _____

Please read ALL of the following statements:

Please note: If you pay privately, payment is required when the service is provided! Please remember that we will bill your health insurance as a courtesy for the services provided. Insurance companies vary in the amount they pay for various services; ultimately, it is your responsibility to pay the portion of the bill that is not paid by your insurance (unless the law or an agreement we have with the insurer provides otherwise.) I authorize payment of benefits to be made on my behalf to Trika Medical Inc. for any services provided to me. In cases assigned to Medicare, the physician accepts the fee determination as the full charge, and the patient is responsible only for the deductible, the coinsurance, and non-covered services.

Signature:_____ **Date:** _____

This is your consent for treatment, which may include outpatient treatment, emergency treatment, laboratory procedures, radiology, medical or surgical treatment or procedures under the physician's special instructions. By receiving care at Trika Medical, you authorize us to share the necessary treatment information with your insurance provider. Please note that you are responsible for any costs not covered by your insurance provider. We kindly ask that you notify us at least 24 hours in advance of any cancellation to avoid a $50 charge. Please note that missed appointments for sleep studies will incur a $300 charge.

Signature:_____ **Date:** _____

I voluntarily consent to video recording during my appointments for clinical, educational, or administrative purposes, as permitted by law. I understand that my privacy will be protected in accordance with HIPAA and state regulations, with the recordings kept securely and accessible only to authorized personnel.

Signature:_____ **Date:** _____

I hereby authorize Trika Medical Inc. and its technology providers and authorized service providers (including VagusX, Inc.), acting on its behalf, to communicate with me regarding referral coordination, appointment scheduling, confirmations, reminders, visit instructions, prescriptions, treatment, and care coordination, account-related communications, and other communications related to treatment and healthcare operations.

Communications may be made by live representatives or through automated technologies, including artificial intelligence (AI)-assisted voice calls, telephone calls, text messages (SMS), email, fax, or postal mail. These communications are intended to support my treatment, the coordination of my care, and healthcare operations and are not marketing communications. Standard SMS text messages and email may not be encrypted and may present privacy and security risks. Message and data rates may apply. I may opt out of receiving text message communications at any time by replying STOP. I may also update my communication preferences for all communication channels by contacting the office. Granting this consent is voluntary and is not a condition of receiving medical treatment.

Signature :_____ Date: _____

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Name/Location of Pharmacy:_____

Medications	Dosage	Instructions

Inhalers (name, dosage, indications)-

Nebulizers (name, dose, indications)-

Oxygen (24/7, as needed at night) Flow in liters _____ Supplier _____

CPAP/BiPAP provider _____ Pressure adjustment _____

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Social Security number:_____ Date of birth:_____

Past medical problems:

___ Pneumonia ___ Any Cancer ___ Tuberculosis
___ High blood pressure ___ Allergies ___ emphysema
___ Rheumatic/Scarlet fever. ___ Pleural effusion ___ Stroke
___ Stomach ulcer/disorder ___ Lung nodule/cancer ___ Angina
___ Kidney stones ___ Heart disease ___ Urinary tract infection
___ Lung problems ___ Jaundice/Hepatitis ___ Restless Legs
___ Thyroid Disease ___ Seizures ___ Sleep apnea/sleep disorder
____ Anemia/Blood Disorder __ Sexually transmitted disease ___ Asthma

Past Surgeries and Hospitalizations

Procedure	Date	Hospital

Medication allergies: (List or Write None):_____

Clinical Histories: Please list any family history and any medical problems. Please include parents, brother(s), sister(s), child(ren) (family members with the illness as well). This section is important and must be completed. Examples include Cancer, Diabetes, High blood pressure, High Cholesterol.

_____
_____
_____
_____

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Patient History Questionnaire

Name: _____ Date of Birth: _____

Lungs:

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

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

Blood in the phlegm - Yes/No If yes, for how long? _____

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

How far can you walk on flat ground without getting out of breath?

_____

Do you notice any difference when breathing while standing, sitting, or lying down? _____

Do you have a runny nose, a stuffy nose, postnasal drip? (Please circle)

Do you have heartburn/acid reflux? If so, how long have you had it? _____

Do you have any chest pain? If so, since when? _____

Do you have swelling in your feet? _____

Have you lost or gained a significant amount of weight? How much?

_____

Sleep:

Are you sleepy during the day? _____

Do you snore? _____

Do you wake up with a headache? _____

Do you have a dry mouth when you wake up? _____

Do you have trouble falling asleep? _____

Do you walk or talk in your sleep? _____

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Social History

Please list your typical consumption of the following:

Coffee: ___cups per day **Tea**:___ cups per day **Soda**:____ cups per day

Other: ____ cups per day **Liquor**: ____ cups per day **Wine**: ____ cups per day

Shots: ___ per day **Cigarettes:** ___ per day **Beer:** ___ cups/cans per day

Have you ever had a sleep study? If you said yes, please specify: _____

Does any family member have sleep disorders? Yes/No ____ Who? _____

Do you have a lot of stress in your life? Yes/No? ____ If the answer is yes, please explain:

_____

Are you allergic to any medication that you know of? Yes/No If the answer is yes, which one?

_____

Do you smoke or have you smoked before? ___ If the answer is yes, indicate how many years you have smoked: _____

How many packs a day do you smoke or did you smoke?

_____

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How likely are you to fall asleep or doze off in the following situations, rather than just feel tired? This questionnaire refers to the likelihood that you will fall asleep during usual daily activities. Use the following scale to choose the number that best fits each situation:

Scale:

0= No possibility of falling asleep 1= Moderate chance of falling asleep

2= Slight possibility of falling asleep 3= High likelihood of falling asleep

Sitting and reading	1	2	3
Watching television	1	2	3
Sitting inactive in a public place	1	2	3
As a passenger in a car for one hour without a break	1	2	3
Lying down to rest in the afternoon when circumstances permit	1	2	3
Sitting and talking with someone	1	2	3
Sitting quietly after a non-alcoholic lunch	1	2	3
In a car, while stopped for a few minutes in traffic	1	2	3
Total Epworth scale score			

Name: _____ **Date of Birth**: _____

Signature: _____

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Authorization to release health information

Patient's name: _____ Date of Birth: _____ SSN: _____

Please send the records by fax or by mail to: Trika Medical, Anurag Sahai M.D.

Tel: 760-242-2333 Fax: 760-242-2337

I authorize Trika Medical to disclose any health information to any PCP or specialist who may request it on my behalf, I have the right to withdraw the authorization at any time. Records requested by a PCP or specialist are free of charge for the patient

☐ **I authorize the information to be sent by fax.** ☐ **I do not authorize the information to be sent by fax**

Name: _____ Relationship to the patient: _____ Date of Birth: _____

Please send by fax:

_____

_____

_____

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No-Show/Last-Minute Cancellation Policy

I, _____ understand that I will be responsible for the no-show fee or the last-minute cancellation fee with less than 24 hours' notice. I am responsible for paying the following fees as applicable.

No-Show/Last-Minute Cancellation Fees:

Office visit: $50

PFT visit: $50

Sleep study: $300

Personal medical records: $25

Signature: _____ Date: _____

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New Patient Appointment Policy & Acknowledgment

Thank you for choosing our Pulmonary & Sleep Medicine practice. We value your time and strive to provide timely care for all of our patients. Because new patient appointments require significant physician time and are often scheduled weeks in advance, missed appointments prevent other patients from receiving needed care.

New Patient No-Show Policy

A **no-show** is defined as failing to arrive for your scheduled appointment without notifying our office in advance, or arriving too late to be seen at the provider's discretion.

By signing below, you acknowledge and understand that:

- Your initial appointment time has been reserved specifically for you.
- If you are unable to attend your appointment, we ask that you notify our office as soon as possible so the appointment may be offered to another patient.
- **Failure to appear for your first scheduled New Patient Appointment without prior notice may result in the practice declining to reschedule another New Patient Appointment.**
- Decisions regarding rescheduling after a missed initial appointment are made at the sole discretion of the practice and provider.
- This policy helps us provide timely access to care for all patients.

We understand that emergencies and unforeseen circumstances may occur. Such situations will be reviewed on a case-by-case basis.

Patient Acknowledgment

I have read and understand the New Patient Appointment Policy. I understand that if I fail to appear for my initial appointment without appropriate notice, the practice may choose not to reschedule me as a new patient.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

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2026 INSURANCE INFORMATION:

It is the patient's responsibility to provide our office with accurate and up-to-date insurance information prior to **each appointment**. Please notify our office in advance of your scheduled visit if there have been any changes to your insurance plan, insurance identification number, member or group number, HMO medical group, primary care provider, or any other information that may affect your insurance coverage.

Providing updated information in a timely manner allows our office to verify your eligibility and benefits and helps ensure that claims are submitted to the correct insurance plan. Please be aware that insurance coverage and benefits are determined by your insurance carrier and may change at any time.

If you fail to notify our office of any changes to your insurance information before your appointment, there is a possibility that services may not be covered by the insurance information we have on file. If your insurance denies or does not cover the services due to outdated, incorrect, or incomplete information, you may be responsible for any charges, balances, or other costs incurred as a result.

We appreciate your cooperation in keeping your insurance information current and providing our office with any updated documentation when requested. This helps us maintain accurate records and minimize potential billing issues or unexpected expenses.

By signing below, you acknowledge that you have read, understand, and agree to comply with this office policy regarding insurance information and financial responsibility.

PATIENT: _____ DATE:_____

SIGNATURE: _____