STUART J. BERNSTEIN, M.D. LUIS J. MESA, M.D.

BERNSTEIN & MESA, M.D.s LLC

PULMONARY DISEASE ❖ CRITICAL CARE ❖ INTERNAL MEDICINE

DATE_____

NAME_____

DATE OF BIRTH_____ SOCIAL SECURITY#_____

ADDRESS_____

CITY,STATE,ZIP_____

HOME
PHONE#_____WORK#_____CELL_____

PHARMACY NUMBER:_____
SEX: M/F (CIRCLE) S/M/D/W (CIRCLE)
SPOUSES NAME_____
NEXT OF KIN(IF NO SPOUSE)
_____PHONE#_____

OTHER ADDRESS(IF DIFFERENT FROM PERMANENT)
ADDRESS_____
CITY, STATE,ZIP_____

EMPLOYER_____

PERSON RESPONSIBLE FOR PAYMENT OF BILL: SELF_____ IF OTHER, YOU MUST COMPLETE:

NAME_____PHONE#_____

ADDRESS_____

UPON REQUEST, I HEREBY AUTHORIZE BERNSTEIN & MESA'S MD'S,LLC TO RELEASE A COPY OF MY MEDICAL INFORMATION TO THE FOLLOWING FAMILY MEMBERS ONLY:

1)
2)
3)

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE BERNSTEIN & MESA'S MD'S,LLC TO FURNISH MY INSURANCE COMPANY OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY ILLNESS AND TREATMENT. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY BERNSTEIN & MESA'S MD'S,LLC DIRECTLY FOR ALL SERVICES RENDERED BY THEM OR THEIR OFFICE.

PATIENT
SIGNATURE_____DATE_____

21110 BISCAYNE BLVD., SUITE 405 ❖ AVENTURA, FL 33180 ❖ PHONE: (305) 937-4400 ❖ FAX: (305) 931-5625

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name:_____

Address:_____

Telephone:_____ Social Security:_____

SECTION B: To the Patient: Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage your to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: BEATRICE PERKINS

Address: 21110 Biscayne Blvd., Suite 405, Aventura, Florida 33180

Telephone: (305) 937-4400 Fax: (305) 931-5625

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name:_____

Signature:_____

Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other_____

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LIVING WILL

Declaration made this ____ day of _____ 20__, I, _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the even that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____

Address: _____

Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (Optional)

_____

_____

_____
Signature of Declarant

_____ _____
Witness to Signature Relationship

_____ _____
Witness to Signature Relationship

*Patient declined to fill out form _____
(Sign here)

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Medical Records Release Form

Complete This Section If We Are Sending Records To Another Physician

I, _____ waive all responsibility regarding the confidentiality of information released to the party listed below. I hereby authorize Dr Stuart Bernstein or Dr Luis Mesa to furnish my records to:

Dr./ Facility _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Complete This Section If We Are Obtaining Records From Another Physician

Physician's Name: _____

Physician's Address: _____

I hereby authorize and request you to release the complete records in your possesion concerning my illness and or treatment. Please include last office notes, bloodwork, and Diagnostic Testing.

Patient's Name: _____

Social Sec #: _____ Date of Birth: _____

Patients Address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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Name _____

DOB __/__/____

Date __/__/____

Allergies _____

Past Medical History

Have you suffered from?

	Yes	No		Yes	No
Diabetes	___	___	High Blood Pressure	___	___
High Cholesterol	___	___	Heart Attacks	___	___
Angina	___	___	Congestive Heart failure	___	___
Asthma	___	___	Pneumonia	___	___
COPD	___	___	Tuberculosis	___	___
Bronchiectasis	___	___	Deep venous thrombosis	___	___
Hay Fever	___	___	Pulmonary embolism	___	___
GERD (reflux)	___	___	Sleep apnea	___	___
Stroke	___	___	Seizures	___	___
Cancer	___	___	Cardiac arrhythmias	___	___

Other (explain)

_____

_____

_____

Past Surgeries

Adenoids/Tonsils	___	___	Cataracts	___	___
CABG (bypass)	___	___	Hysterectomy	___	___
Appendectomy	___	___	Gallbladder	___	___
Prostate surgery	___	___	Breast surgery	___	___
Lung surgery	___	___	Pacemaker	___	___

Other (explain)

_____

_____

_____

Medical Conditions in Family

Father _____

Mother _____

Siblings _____

Social and Occupational History

Married	___	Single	___	Widow	___	Divorced ___	Children (how many) ___
Smoking		No	___	Yes	___	How many packs/day ___	How long ___ years
Alcohol		No	___	Yes	___	How many drinks/day ___	How long ___ years
Recreational Drugs		No	___	Yes	___	Explain _____	
Any Pets at home		No	___	Yes	___	Explain _____	
Any Recent travel		No	___	Yes	___	Where/when _____	

Please List Occupations you have had:

_____

_____

_____

Review of Systems

Have you had any of the following recently:

	Yes	No
Constitutional		
Fever	___	___
Chills	___	___
Abnormal night sweats	___	___
Weight loss	___	___
Loss of appetite	___	___
Ear Nose Throat		
Sneezing	___	___
Nasal congestion	___	___
Frequent colds	___	___
Postnasal drip	___	___
Ear pain	___	___
Ear ringing	___	___
Hearing loss	___	___
Sore throat	___	___
Respiratory		
Cough	___	___
Shortness of breath	___	___
Wheezing	___	___
Chest tightness	___	___
Cough up blood	___	___
Cough up phlegm	___	___
Need to sleep with several pillows to breath better	___	___
Genitourinary		
Burning to urinate	___	___
Frequent urination	___	___
Blood in urine	___	___
Urinary incontinence	___	___
Waking up to urinate	___	___
Kidney stones	___	___
Renal insufficiency or dialysis	___	___
Psychiatric		
Depression	___	___
Anxiety	___	___
Bipolar disorder	___	___
Neurological		
Headaches	___	___
Numbness	___	___
Tingling	___	___
Weakness of part of body	___	___
Neuropathy	___	___
Skin		
Rash	___	___
Skin bruises	___	___
Wounds	___	___
Skin cancers	___	___
Psoriasis	___	___

	Yes	No
Eyes		
Vision loss	___	___
Double vision	___	___
Glaucoma	___	___
Macular degeneration	___	___
Cataracts	___	___
Gastrointestinal		
Heartburn	___	___
Nausea	___	___
Vomiting	___	___
Abdominal pain	___	___
Diarrhea	___	___
Bloody stools	___	___
Black stools	___	___
Constipation	___	___
Cardiovascular		
Chest pain	___	___
Palpitations	___	___
Swelling of feet/legs	___	___
Sensation of fainting	___	___
Fainting	___	___
Pain on legs with walking	___	___
Waking up suddenly with shortness of breath	___	___
Musculoskeletal		
Joint pain	___	___
Stiffness	___	___
Swollen joints	___	___
Back pain	___	___
Osteoporosis	___	___
Muscle aches	___	___
Hematologic/lymphatic		
Anemia	___	___
Bleeding problems	___	___
Enlarged lymph nodes	___	___
Endocrine		
Excessive thirst	___	___
High blood sugar/diabetes	___	___
Thyroid disorders	___	___
Adrenal disorders	___	___
Pituitary disorders	___	___
Infertility	___	___
Allergic/Immunologic		
Hay fever	___	___
Lupus/Rheumatoid arthritis	___	___
Other autoimmune disease	___	___
Immune deficiency	___	___
HIV	___	___

Medication List

Medication	Dose	How often

Vaccination

	Yes	No		
Influenza	____	____	If yes, when?	_____
Pneumonia	____	____	If yes, when?	_____

Sleep Questionnaire

Bed time	working days	_____	Days off	_____
Get up time	working days	_____	Days off	_____
Usual time to fall asleep		_____		
How many times do you wake up at night?		_____		
What wakes you up?		_____		
		_____		
		_____		
Do you feel tired/sleepy during daytime?		Yes _____	No	_____
Do you snore?		Yes _____	No	_____
Do you wake up chocking?		Yes _____	No	_____
Do you take naps?		Yes _____	No	_____
If yes, what time and for how long?		_____		
Do you wake up with a dry mouth?		Yes _____	No	_____
Do you wake up with headaches?		Yes _____	No	_____
Do you fall asleep involuntarily?		Yes _____	No	_____
If yes, in what circumstances (explain)		_____		
		_____		
		_____		
Do you fight sleep while driving		Yes _____	No	_____
Do you dream at night?		Yes _____	No	_____
Do you dream when you take naps?		Yes _____	No	_____
Do you have "restless legs" when you go to bed?		Yes _____	No	_____
During emotional situations, do you feel weak?		Yes _____	No	_____
If yes, explain		_____		
		_____		

EPWORTH SLEEPINESS SCALE

This questionnaire will help your physician to measure your general level of daytime sleepiness.

Name | Date of birth | Date

How likely are you to doze off or fall asleep in the situations described below, *in contrast to feeling just tired?*

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the *most appropriate number* for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOSING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (eg, a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

continued on reverse side