NEW PATIENT REGISTRATION

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www.pulmonary.site

Today's Date: ___/___/_____

Patient Information

Full Name: _____ DOB: ___/___/_____ SSN: _____-_____-_____

Gender: M ☐ F ☐ Language: _____ Race: _____ Ethnicity: _____

Street Address: _____Apt#: _____

City: _____ State: _____ Zip: _____ Marital Status S☐ M ☐ W☐ D☐

Phone: (Home) _____ (Cell) _____ (Work) _____

Email Address: _____

Guarantor Information

Full Name: _____ DOB: ___/___/_____ SSN: _____-_____-_____

Street Address: _____Apt#: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Emergency Contact

Check here if same as guarantor ☐

Full Name: _____ DOB: ___/___/_____

Phone: (Home) _____ (Cell) _____ (Work) _____

Insurance

Primary insurance: _____ Policy #: _____Group#: _____

If your insurance requires a referral or authorization, it is your responsibility to request it from your primary care physician. If we do not have one on file 48 hours prior to your appointment, we will reschedule it for a later date.

Secondary Insurance : _____Policy #: _____Group #:_____

Physician Information

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____Suite#: _____City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: _____ Fax: _____

Address: _____Suite#: _____City: _____ State: _____ Zip: _____

Pharmacy Information

Pharmacy Name: _____ Phone: _____ Fax: _____

Address: _____City: _____ State: _____ Zip: _____

Office Policies

Please read carefully and sign below. You will get to keep a signed copy for your records.

- Any messages left with the answering service are returned on the following business day.

- **No test results will be given over the phone.**

- If your insurance requires a referral or authorization, it is your responsibility to request it from your primary care physician. If we do not have one on file 48 hours prior to your appointment, we will call you to reschedule for a later date.

- All copays previous balances must be paid prior to your appointment. If you are unable to, you must contact the office manager to make a payment arrangement. Failure to pay these amounts will result in your appointment being rescheduled, and there are no exceptions.

- Please allow up to a week to schedule any additional testing and procedures prescribed by our medical staff. We will call you regarding date, location and preparations for the procedure.

- **A $25.00 fee will be charged to your account for the following reasons:**

    - Same-day appointment cancellations, or no call/ no-show for your appointment ($100 for a breathing test)
    - Any returned checks
    - The completion of **ANY** forms, collected prior to form completion. (Please allow 5-7 business days for completion)
    - We charge $1.00 per page and $0.25 per page thereafter, for any medical records copied and released at the patient's request. Payment must be received prior to completion. Please allow 5-7 business days to complete the request. **We do not email patient documents under any circumstances.**

- **Prescription refills:**

    - Please allow 48 – 72 hours for prescription refills.
    - Please call your pharmacy for any prescription refills. If they require approval, they will fax our office for a signature then it is refilled.
    - If in any case your prescription cannot be refilled in this way, leave us a message with your name, medication, and pharmacy telephone number, and allow 48-72 hours for processing.

By signing below I am agreeing to the above office policies and I understand them. I agree that I have been given an opportunity to ask any questions I may have about these policies before signing below. I understand no exceptions are made to these policies under any circumstances.

_____ _____

Print Patient/Representative Name Patient/Representative Signature

_____

Today's Date

Patient Authorization for Disclosure of Protected Health Information (PHI)

What is PHI?

Any office notes regarding my condition and treatment, lab work, radiology testing, diagnostic tests, operative reports, procedural reports, medicine/prescription information, and billing information. This also includes any psychological or psychotherapy information.

I, _____ voluntarily authorize Pulmonary Medicine Associates to disclose or release PHI to the following parties (Please check all that apply):

_____ My Primary Care Physician

_____ My Specialist

_____ Insurance companies and litigators involved in my case

_____ Hospitals/Outpatient centers

Please write any others you are willing to share your PHI with:

Spouse Name: _____ DOB: _____

Parent Name: _____ DOB: _____

Child Name: _____ DOB: _____

Other Name: _____ DOB: _____

Disclosure or use of PHI is for the purpose of continued care, review for payment of medical insurance claims, or public health unless you restrict us in writing.

Please **DO NOT** release or disclose any PHI to the following parties:

_____

_____

_____ This authorization will end on this date: _____

_____ This authorization will be in place without date restriction.

I have been provided the opportunity to review the "Notice of Patient Privacy Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights: • The right to review the "Notice" prior to acknowledging this consent, • The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and • The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand the information to be released may include records related to behavior or mental health care, alcohol and drug abuse treatment, HIV/AIDS and genetics. This authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to our facility. I understand Pulmonary Medicine Associates will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization does not expire unless I indicate a specific date.

_____ _____

Print Patient/Representative Name Patient/Representative Signature

_____

Today's Date

Medical Information

Medications: Prescription and non-prescription medicines, vitamins, home remedies, herbs, etc.

***If you already have a medication list with you, please tell the receptionist and she will make a copy for you.**

Medication	Dose (e.g., mg/pill)	Doses per day

Allergies or reactions to any medications:

_____

_____

Medical Information

What is the main reason for today's visit, and when did you first notice this problem?

Medical History:

Please check if you have ever been diagnosed with the following:

☐ Allergies	☐ Alzheimer's	☐ Anemia	☐ Aneurysm	☐ Anxiety
☐ Aspirations	☐ Asthma	☐ Bronchiectasis	☐ Osteo-Arthritis	☐ Bronchitis
☐ Cancer, if so what type? _____		☐ Cardiac Arrest	☐ Cardiac Arrhythmias	☐ Colitis
☐ Congestive Heart Failure	☐ COPD	☐ Coronary Artery Disease	☐ Chronic Cough	☐ Cystic fibrosis
☐ Diabetes	☐ Emphysema	☐ Fissure	☐ GERD/Heart burn	☐ Heart disease
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ Hernia	☐ HIV/AIDS
☐ Hodgkin's Disease	☐ Hypertension	☐ Hyperthyroidism	☐ Hypothyroidism	☐ Incontinence
☐ Irregular Heartbeat	☐ Kidney Stones	☐ Leukemia	☐ Melanoma	☐ Non-Hodgkin's Lymphoma
☐ Neuropathy	☐ Migraines	☐ Obesity	☐ Parkinson's	☐ Pleural Effustion
☐ Pleurisy	☐ Pneumonia	☐ Pneumothorax	☐ Pulmonary Embolism	☐ Pulmonary Fibrosis
☐ Pulmonary Hypertention	☐ Renal Failure	☐ Rheumatic Fever	☐ Raynaud's Phenomenon	☐ Sarcoidosis
☐ Scleroderma	☐ Scoliosis	☐ Seizures	☐ Sleep Apnea	☐ Stroke, TIA, CVA
☐ Stomach Ulcers	☐ Thyroid Disorder	☐ Tuberculosis	☐ Rheumatoid Arthritis	☐ Sinusitis

Others not listed: _____

Please check any allergies you currently have:

☐ Ace inhibitors	☐ Anesthesia	☐ Antihistamines	☐ Aspirin	☐ Codeine
☐ Dairy	☐ Iodine	☐ Latex	☐ Mold	☐ Penicillin
☐ Prednisone	☐ Sulfa Drugs	☐ X-ray dye	☐ No known allergies	☐ Other (List below)

_____

_____

What was the date of your most recent immunization?

Influenza (Flu shot) : _____ Pneumovax (Pneumonia): _____Other: _____

Please list all prior operations/hospitalizations:

Type of surgery/hospitalization	Name of hospital or facility	Date: (MM/YY)

Have you ever been exposed to the following? (Please circle)

Asbestos	Ammonia	Agent Orange	Burns wood in home
Carpenter's wood dust	Chemical/toxin	Chemical fumes/gases	Chlorine
Coal dust	Feathers	Fiberglass	Mold growing in home
UV overexposure	Radiation	Silica	Soldering/welding

Oil or kerosene burning heater

Family History

Please indicate family members with any of the following conditions. (i.e. mother, father, sibling, grandparent, aunt or uncle)

Asthma	_____	High cholestoerol	_____
Cancer	_____	Hypertension	_____
(list type)	_____	Lupus	_____
COPD	_____	Rheumatoid Arthritis	_____
Cystic Fibrosis	_____	Sickle Cell Disease	_____
Diabetes	_____	Stroke	_____
Heart problems	_____	Thyroid Disease	_____
		Tuberculosis	_____

Social History:

Occupation: _____
Marital status: S ☐ M ☐ W ☐ D ☐

Do you have any children? ☐ Yes How many? _____
☐ No

Do you exercise? ☐ Yes How often? _____
☐ No

Do you have any pets? Dogs _____ Cats _____ Birds _____

Cigarettes:

☐ Never Smoked	
☐ Former Smoker	Quit date: _____ _____ Packs per day for _____ years
☐ Current Smoker	Age you started smoking? _____ _____ Packs per day for _____ years How soon after waking up do you smoke your first cigarette? (circle) 5 minutes 6-30 minutes 31 to 60 minutes after 60 minutes

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes, _____ drinks per week ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you drink any caffeine? ☐ Yes, _____ cups per day ☐ No