# PATIENT REGISTRATION FORM

MR#: _____ (Office Use Only) Initial Date: _____/_____/_____ ❑ Revised—See Addendum

## PATIENT INFORMATION

**Patient's Name:** _____ **Preferred Name:** _____
LAST FIRST MI

**Social Security #:**_____-_____-_____ **Date of Birth:** _____/_____/_____ **Sex:** ❑ **Male** ❑ **Female**

**Address:** _____
STREET CITY STATE ZIP

**Home Phone #:** (_____)_____ **Mobile #:** (_____)_____

**Email:** _____**Consent to Web Enable Access to Patient Portal** ❑ **Yes** ❑ **No**

**Marital Status:** ❑ **Single** ❑ **Married** ❑ **Widowed** ❑ **Divorced**

**Spouse's Name:** _____ **Spouse's Date of Birth** _____/_____/_____
(If Applicable)

**Race:** ❑ **American Indian/Alaska Native** ❑ **Asian** ❑ **Native Hawaiian/Other Pacific** ❑ **Black/African American**
❑ **White** ❑ **Hispanic** ❑ **Other Race** ❑ **Other Pacific Islander** ❑ **Unreported/Refused to Report**

**Ethnicity:** ❑ **Hispanic or Latin** ❑ **Not Hispanic** ❑ **Unreported/Refused to Report**

**Language:** ❑ **English** ❑ **Spanish** ❑ **Indian** ❑ **Russian** ❑ **Other:** _____

## EMPLOYMENT

❑ **Full—Time** ❑ **Part—Time** ❑ **Retired** ❑ **Student** ❑ **None**

**Employer:** _____

**Occupation:** _____ **Business #:** (_____)_____

**Business Address:** _____
STREET CITY STATE ZIP

## PHYSICIAN / PHARMACY INFORMATION

**Primary Care Physician:** _____ **Phone #:** (____)_____

**Referring Physician:** _____ **Phone #:** (____)_____

**Preferred Pharmacy:** _____ **Phone # / Location:** _____

# PATIENT REGISTRATION FORM

**DATE:** _____/_____/_____

**PATIENT'S NAME:** _____ **DATE OF BIRTH:** _____/_____/_____

## ASSIGNMENT OF BENEFITS

I hereby assign to Tri-County Pulmonary & Sleep any insurance or other third-party benefits available for health care services provided to me. I authorize direct remittance of payment of all insurance benefits to Tri-County Pulmonary & Sleep for all covered medical services and supplies provided to me during all courses of treatment and care provided by the Tri-County Pulmonary & Sleep and/or its affiliated entities. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by Tri-County Pulmonary & Sleep. I understand that this assignment of benefits does not relieve my ultimate responsibility for all charges not covered and paid by insurance.

## CONSENT TO TREAT

I voluntarily consent and authorize Tri-County Pulmonary & Sleep and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf.

By signing below, I agree to the terms of this document which I have read and had the opportunity to ask questions about and I acknowledge that I have the opportunity to request and receive a copy of this office's Notice of Privacy Practices and Financial Policy which explains how my medical and billing information will be used and disclosed.

_____ _____

**PATIENT OR PATIENT'S REPRESENTATIVE** **DATE**

**FOR PATIENT REPRESENTATIVES:**

My relationship to the patient is _____ and I have signed this consent on the patient's behalf.

_____ _____

**WITNESS** **DATE**

# PATIENT REGISTRATION FORM

Patient's Name: _____ Date of Birth: _____/_____/_____

## Responsible Billing Party

***Please complete if the responsible billing party is different from the patient listed above.***

Name: _____ Date of Birth: _____/_____/_____
Last First MI

Address: _____
Street City State Zip

Social Security #: _____-____-_____ Phone #: (_____)_____ Sex: ☐ Male ☐ Female

Relationship to patient: ☐ Spouse ☐ Partner ☐ Durable Power of Attorney ☐ Other: _____
Please specify

## Primary Insurance Information

☐ No, I do not have medical insurance.

Insurance Name: _____ Employer: _____

Policy Holder Name: _____ Date of Birth: ____/____/____
Last First MI

Social Security #:_____-____-_____ Member ID: _____ Group #: _____

## Secondary Insurance Policy (if any)

Insurance Name: _____ Employer: _____

Policy Holder Name: _____ Date of Birth: ____/____/____
Last First MI

Social Security #:_____-____-_____ Member ID: _____ Group #: _____

## Emergency Contact

Name: _____ Telephone #: (_____)_____

Relationship to patient: _____

# PATIENT REGISTRATION FORM

**logo**

**Patient's Name: _____Date of Birth: _____/_____/_____**

**Today's Date: _____ /_____ /_____**

## Advanced Directives

**Do you have, or would you like to name a Surrogate Decision Maker?**
A surrogate decision maker is a trusted individual who can make medical decisions for you in the event you are not able to make decisions for yourself. This is a verbal preference and not a legal document.

☐ **Yes or** ☐ **No** *If yes, please include the information below*

1) Surrogate's Name: _____

   Phone #: _____

   Relationship to patient: _____

2) Alternative Surrogate's Name : _____

   Phone #: _____

   Relationship to patient: _____

**Do you have a written legal Advanced Directive/Living Will or Medical Power of Attorney?** ☐ **Yes or** ☐ **No**
If yes, please mark the box next to each of the following advanced directive(s) you have:

☐ Advanced Directive to Physician's and Family or Surrogates / Living Will

☐ Medical/Durable Power of Attorney

*If you have a written Advanced Directive(s), please bring a copy of your form(s) with you to our office and allow us to keep a copy in your medical records*

If you do not have a Written Advanced Directive and would like a copy of the blank forms to take home please let us know. These forms are also available on our website.

# PATIENT REGISTRATION FORM

**Room # _____**

## PATIENT/FAMILY MEDICAL HISTORY FORM

**Today's Date: _____ /_____ /_____**

**Patient's Name: _____Date of Birth: _____/_____/_____**

***Pharmacy Name: _____Location:_____***

## History of Present Illness

•Reason for visit today (Chief Complaint):_____

• When did your symptom(s) first start:_____

• What makes your symptom(s) better: _____

• What makes your symptoms worse:_____

## Personal Medical History

**Height: _____Ft. _____In. Weight: _____**

(Office use only: T_____ HR_____O2%_____LF_____RR_____BP_____N_____)

**Medications:**

List all your current medications and dosages or provide a list (☐ See attached list):

(Continue on back of page if more space is needed)

| **Medication** | **Strength** (mg, units) | **Directions** (# of tabs/puffs, etc. ***and*** how many times a day) |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |
| 13. | | |

**MEDICATION ALLERGIES** ☐ No, I do not have any medication allergies

List any allergies to medications and specify what kind of reaction you've experienced from taking that medication.

# PATIENT REGISTRATION FORM

**Medication** **Reaction**

1._____ _____

2._____ _____

3._____ _____

Patient's Name: _____Date of Birth: _____/_____/_____ (2)

**PATIENT PAST / CURRENT MEDICAL HISTORY**

(Please place an (X) by all the conditions listed below that you have been diagnosed with in the **past** or **presently**)

| | | | | |
|---|---|---|---|---|
| __Asthma | __Tuberculosis | __Heart Disease | __Diabetes | __Thyroid disease |
| __Chronic bronchitis | __Pulmonary HTN | __High Blood Pressure | __Anemia | __Sleep Apnea |
| __Emphysema | __Pulmonary Fibrosis | __ High Cholesterol | __Kidney disease | __Snoring |
| __COPD | __Pulmonary Embolism | __Cardiac stents | __Reflux/GERD | __Restless Legs |
| __Pneumonia | __Chronic Cough | __Stroke | __Lung Nodule/Mass | __Pleural Effusion |
| __Allergic Rhinitis | __Shortness of Breath | __Heart attack | __Cancer (type):_____ | |

Please list all other past or present medical conditions you have been diagnosed with that are not listed above:

_____

_____

**PREVIOUS SURGERY** ☐ No, I have never had any surgeries

(Lung surgery, Heart surgery, ALL other surgeries)

1. _____ 4._____

2. _____ 5._____

3. _____ 6._____

**PAST HOSPITALIZATIONS** ☐ No, I have never been hospitalized

Hospitalizations (continue on back of page if more space is needed).

| Hospital & City | Reason | Physician | Year |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**SOCIAL HISTORY**

Are you working now? ☐ Yes What is your occupation? _____

☐No What was your occupation? _____ ☐ Retired ☐ Unemployed

Have you been exposed to asbestos, dust or strong fumes at your work? ☐No ☐Yes

If yes, please describe: _____

Do you keep animals at home? ☐No ☐Yes How many /What type: _____

Have you ever smoked cigarettes? ☐No ☐Yes If yes: Do you smoke now? ☐No ☐Yes

At what age did you start smoking? _____

At what age did you stop smoking? _____

How many packs a day do/did you smoke? _____

Do you use any other type of tobacco products other than smoking? ☐Yes ☐No If yes: What type? _____

Do you drink caffeine? ☐No ☐Yes How often/What kind?_____

Do you consume alcoholic beverages? ☐No ☐Yes

# PATIENT REGISTRATION FORM

If yes: How often: _____ times per ☐ Week ☐ Month ☐ Year
If yes: How many drinks do you have on a typical day when you are drinking? _____
Do you consider yourself an alcoholic? ☐No ☐Yes

Do you use recreational/illicit drugs? ☐No, never ☐Yes, in the past ☐Yes, currently
If yes, Please describe _____

Patient's Name: _____ Date of Birth:_____/_____/_____ (3)

**FAMILY MEDICAL HISTORY** ☐ No Known Family History of Medical Illness/Disease ☐ I was adopted

**Please specify which relative** *AND* for distant relatives please specify if they are on (P) PATERNAL *OR* (M) MATERNAL side.
**(**Example: Diabetes / Mother, (P) Grandfather, (M) Aunt, brother**)**

| Disease | Relative | Other Diseases (list) | Relative |
|---|---|---|---|
| Asthma | | Diabetes | |
| Emphysema or COPD | | Other: | |
| Lung cancer | | Other : | |
| Heart disease | | Cancer : What Type | Who: |
| Blood clotting disorder | | Cancer : | |
| High blood pressure | | Cancer : | |
| High cholesterol | | Cancer : | |

**PREVENTIVE CARE**

Have you had a Flu shot since the most recent Sept. 1st? ☐Yes ☐No Date: ___/___/___ Location: _____

Have you had a Pneumonia shot in the past 10 years? ☐Yes ☐No Date: ___/___/___ Location: _____

Have you received a TB Skin Test? ☐Yes ☐No Date received ___/___/___ Results? ☐Pos ☐Neg
If TB test was positive was a Chest X-ray done? ☐Yes ☐No Results? ☐Abnormal ☐Normal
Have you received treatment for TB? ☐Yes ☐No

**REVIEW OF SYSTEMS:** Please check (√) if you are currently experiencing any of these symptoms.

| System | Symptoms |
|---|---|
| General | ___Fever ___Sweats/chills ___Weakness ___Weight change ___Fatigue ___Irritability |
| Sleep | ___ Snoring ___ I have been told that I quit breathing ___ Choking/ gasping for air at night ___Restless legs ____ Excessive Sleepiness ____ Nightmares |
| Eyes | ___Redness ___Excessive tearing ___Discharge ___Sensitivity to light ___Visual changes |
| Ears | ___Pain ___Deafness ___Ringing in ears ___Vertigo ___Itching ___Discharge |
| Nose | ___Frequent colds ___Sinus infections ___Frequent nosebleeds ___Snoring |
| Mouth/throat | ___Dental problems ___Jaw pain or clicking ___Postnasal drainage ___Dry mouth ___Sore throat ___Hoarseness ___Frequent throat clearing |
| Endocrine | ___Thyroid disorder ___Goiter ___Feel hot or cold when others are not affected |
| Respiratory | ___Persistent cough ___Sputum/phlegm ___Wheezing ___Coughing up blood ___Pain on breathing ___Shortness of breath ___Difficulty breathing while lying flat |
| Cardiovascular | ___Chest discomfort ___Swelling of ankles ___Palpitations ___Lightheadedness ___Blood clots ___ fainting |

# PATIENT REGISTRATION FORM

| | |
|---|---|
| Gastrointestinal | ___Heart burn ___Abdominal pain ___Constipation ___Bloody or black stools ___Jaundice<br>___Difficulty swallowing ___Nausea/vomiting/diarrhea |
| Genitourinary | ___Difficulty urinating ___Painful urination ___ Frequent urination ___ Sexual problems<br>___Kidney stones WOMEN: date of last menstrual period_____ |
| Musculoskeletal | ___Limited movement of joints ___Swelling of joints ___Painful Joints___ Back or neck pain |
| Skin | ___Color changes ___Skin eruptions ___Itching ___Scaling ___Easy bruising ____Hives |
| Neurologic | ___Frequent headaches ___Dizziness ___Numbness ___ Muscle weakness ___Forgetfulness |
| Psychiatric | ___ Anxiety ___ Depression ___ Hallucinations |

## PATIENT RECORD OF DISCLOSURES

Date: _____ /_____ /_____

Patient's Name: _____ Date of Birth: _____/_____/_____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

☐Home Telephone: _____
- ☐OK to leave message with detailed information
- ☐Leave message with call-back number only

☐Work Telephone: _____
- ☐OK to leave message with detailed information
- ☐Leave message with call-back number only

☐Cell Telephone: _____
- ☐OK to leave message with detailed information
- ☐Leave message with call-back number only
- ☐Text message with appointment reminder

☐Other: _____
_____

## Release of Information

I hereby authorize Tri-County Pulmonary & Sleep to release my information to any medical provider such as physician, medical equipment company, or hospital- as well as any insurance company and/or responsible billing party. This information may include diagnosis, records of any treatment, or any examinations rendered.

In addition to the above release, I authorize Tri-County Pulmonary & Sleep to release any information to:

**Please print name(s)/phone number(s) and relation to patient**

☐ Spouse/Partner: _____ ☐ Parent: _____

☐ Other: _____ ☐ None

_____ _____

# PATIENT REGISTRATION FORM

Patient Signature Date

## Consent to Obtain Medication History from an External Source

I authorize Tri-County Pulmonary & Sleep to view any and all of my available Prescription History from an External Source. I am aware that Tri-County Pulmonary & Sleep uses a secure connection to Surescripts E-Prescriptions to send and receive prescriptions electronically.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient or Patient Representative | Date | Relationship to Patient in not signed by patient |