

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 #: (____) _____

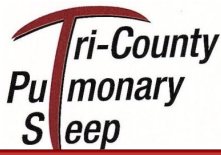
Business Address: _____
STREET CITY STATE ZIP

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

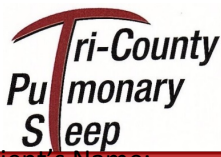
DATE

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: _____

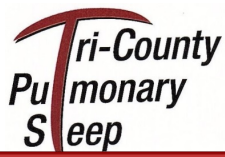
Policy Holder Name: _____ Date of Birth: ____/____/____
Last First MI

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

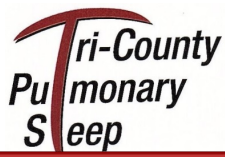
If yes, please mark the box next to each of the following advanced directive(s) you have:

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

<u>Medication</u>	<u>Reaction</u>
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**)

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Pulmonary HTN | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Cardiac stents | <input type="checkbox"/> Reflux/GERD | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Nodule/Mass | <input type="checkbox"/> Pleural Effusion |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heart attack | <input type="checkbox"/> 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).

<u>Hospital & City</u>	<u>Reason</u>	<u>Physician</u>	<u>Year</u>
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: _____

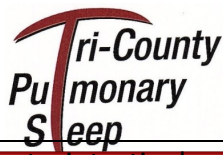
Have you received a TB Skin Test? Yes No Date received ____/____/____ Results? Pos Neg

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



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Gastrointestinal	<input type="checkbox"/> Heart burn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody or black stools <input type="checkbox"/> Jaundice <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nausea/vomiting/diarrhea
Genitourinary	<input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Sexual problems <input type="checkbox"/> Kidney stones <input type="checkbox"/> WOMEN: date of last menstrual period _____
Musculoskeletal	<input type="checkbox"/> Limited movement of joints <input type="checkbox"/> Swelling of joints <input type="checkbox"/> Painful Joints <input type="checkbox"/> Back or neck pain
Skin	<input type="checkbox"/> Color changes <input type="checkbox"/> Skin eruptions <input type="checkbox"/> Itching <input type="checkbox"/> Scaling <input type="checkbox"/> Easy bruising <input type="checkbox"/> Hives
Neurologic	<input type="checkbox"/> Frequent headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Forgetfulness
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> 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
- Cell Telephone: _____
 - OK to leave message with detailed information
 - Leave message with call-back number only
 - Text message with appointment reminder
- Work Telephone: _____
 - OK to leave message with detailed information
 - Leave message with call-back number only
- Other: _____

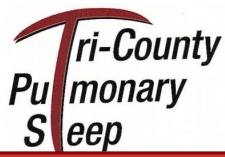
Release of Information

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