PULMONICS PLUS

NEW PATIENT PAPERWORK

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name *(First, M.I., Last)*_____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Address _____

Phone Number _____ Social Security # _____ Driver's License # _____

Employer _____ Phone _____

Employer Address _____

Primary/Referring Physician _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Pharmacy Name _____ Phone Number _____

Address _____

Responsible Party

(If different from patient)

Name _____ Relationship to Patient _____

Address_____

Phone Number _____ Date of Birth _____ Social Security # _____

Employer _____ Phone Number _____

Employer Address_____

Insurance Information

(or copy of insurance card)

Insurance Company _____ Phone Number _____

Address _____

Subscriber ID # _____ Group # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Insured's Social Security # _____ Date of Birth _____ Male / Female

Secondary Insurance Information

Insurance Company _____ Phone Number _____

Subscriber ID # _____ Group # _____

I hereby assign, transfer, and set over to Pulmonics Plus all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____

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Patient Name_____ **DOB:** _____ **Family Physician:** _____
Home Phone: _____ **Cell Phone:** _____ **Email:** _____@_____

GENERAL MEDICAL INFORMATION

Please list respiratory or pulmonary issues you would like to address *(for sleep related issues ask for additional questionnaire)*:_____

❒ NO ❒ YES Do you have shortness of breath *(if yes, please specify)*: _____
If yes, also: How much can you walk (in terms of 1, 2 or 3 blocks, etc) _____

❒ NO ❒ YES Shortness of breath on lying flat. How many pillows do you use to sleep? _____

❒ NO ❒ YES Leg or ankle swelling Baseline weight _____ lbs

❒ NO ❒ YES Do you wheeze *(if yes, specify)*:
❒ Morning ❒ Evening ❒ All day ❒ After food ❒ Nasal drip

❒ NO ❒ YES Do you have a cough *(if yes, specify)*:
❒ Dry ❒ Productive ❒ Blood ❒ After food ❒ Nasal drip

❒ NO ❒ YES Does something trigger above symptoms *(if yes, specify)*: _____

Write in type and year of any operation/surgery you have had *(use next page if needed)*:
_____
_____
_____

Mark all current medical illnesses you have:

❒ Afib/Lung or leg clot	❒ Heart burn/stomach	❒ Pacemaker/Stent/MI
❒ Anxiety/Depression	❒ High BP/Cholesterol	❒ Pulm. Hypertension
❒ Cancer: _____	❒ Kidney issue: _____	❒ Seizure/Stroke/TIA
❒ COPD/Asthma	❒ Liver issue: _____	❒ Sleep apnea
❒ Diabetes/Thyroid	❒ Lung fibrosis/ILD or IPF	❒ Other: _____

List ALL medications and dosage (including sleeping pills and any mood meds)

ALLERGIES: Please list all medications (prescription & non) that you are allergic to, *including reaction*

Allergies to the following:
❒Pollen ❒Grass ❒Mold ❒Dust ❒Hay ❒Weather ❒Perfumes ❒Animals: _____

Do you have any pets in your home? _____ If yes, please specify: _____

Alcohol, tobacco or drug use? _____
If yes, please specify how much, how often and for how many years: _____

Family History- Please specify if one had Asthma/sarciodosis, etc.

Illness	Family Member(s)	Maternal/Paternal	Onset Age	Died at age…

Please list past and current occupations: _____

Any past exposure to toxic or industrial ages (dust, chemicals, etc.): _____ Please specify: _____

Any exposure to:
❒ Tuberculosis ❒ Asbestosis ❒ Lead ❒ Other: _____

Serious injuries or accidents: _____

Have you had a Bronchoscopy? _____ If yes, when? _____ Results: _____

Have you had an Echocardiogram? _____If yes, when? _____ Results: _____

Have you had a CAT scan of Chest? _____If yes, when? _____ Results: _____

List any additional health information you think we need to be aware of:
_____
_____
_____
_____
_____

Are you under the care of a cardiologist (heart doctor)? ❑Yes ❑No Dr._____

Are you under the care of any other specialists? ❑Yes ❑No Dr._____

OFFICE USE ONLY:
Verified & entered by (initial): _____ Date: _____

This form is to confirm you authorization to use or disclose your protected health information for a special purpose.

I, _____, give my authorization to use or disclose my protected health information to the following individual(s) or group(s).

This should be names of relative or friends we may discuss your health issues with. You should list at least one person who helps you when you are ill.

_____ _____

_____ _____

_____ _____

I authorize **PULMONICS PLUS** or their representative to leave messages via the following. If you don't want to be contacted by one of the following, do not place a number by it. **Please number in order of preference**:

_____ Home answering machine
_____ Work voice mail
_____ Cell phone
_____ Text message
_____ Email _____

I understand that I may revoke this authorization at any time, and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Print name: _____

Signature: _____ Date: _____

This must be completed in order for ANY information to be disclosed to a spouse, family member, organization, or individual that assists you with your medical care, appointments, or insurance.

Patient Name: _____ Date of Birth: _____

Assignment of Insurance Benefits:
I hereby authorize direct payment of my insurance benefits to PULMONICS PLUS, or the physician individually, for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are covered benefits. I understand and agree that I will be responsible for any co-pay or balance due.

Medicare/Medicaid/Insurance Benefits:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's or my records that these programs may request. I hereby direct that payment of my dependent's or my authorized benefits be made directly to the PULMONICS PLUS, or the physician on my behalf.

Authorization to Release Non-Public Personal Information:
I certify that I have received and read a copy of the PULMONICS PLUS Patient Information Privacy Policy. I herby authorize PULMONICS PLUS, or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to Mail, Call or Email:
I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize the PULMONICS PLUS staff, or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointments reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying PULMONICS PLUS to that effect in writing.

Lab/X-Ray/Diagnostic Services:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Financial Responsibility Agreement:
I understand and agree that I will be financially responsible for any and all charges not paid by my insurance for my visits. This includes medical service or visit, lab testing, and any other screening service or diagnostic ordered by the physician or staff. I understand and agree that it is my responsibility and the responsibility of the physician, or office, to know if my insurance will pay for medical service or visit. I understand and agree it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, usual and customary limit and I agree to make full payment. I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible to make full payment.

No-Show, Cancellations and Rescheduling:
We understand that circumstances may arise that could affect your availability for your scheduled appointment. Missing your appointment without properly notifying the office though, prevents another patient from receiving much needed care. Vice-versa, another patient's failure to notify the office to cancel an appointment may prevent you from being able to schedule a visit due to a seemingly full schedule. Due to the effect on all patients, a **no-show fee of $25-$150** may be charged to your account, depending on the appointment type.

No-Show fee(s) are not covered by insurance companies and are the patient's responsibility.

I acknowledge that I have been informed of the no show fee policy and fees. I understand these fees are not covered under my insurance plan, and I will be held responsible.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

(If different from patient)
Guarantor Name: _____
(Please print)