PULMONARY / SLEEP PATIENT REGISTRATION FORM

Welcome to Tampa Bay Pulmonary Medicine, P.A., Ivan F. Ackerman, M.D., and Jonathan P. Axel, M.D. Please fill out this entire form and attach your driver's license and insurance cards so that the front desk person may copy them. PLEASE PRINT.

PATIENT INFORMATION

Name: ______________________ **SOC #:** ______________ **D.O.B.:** ______________ **Sex: M F**

Address: ______________________________ **City:** ______________ **State:** ______ **Zip:** ______

Home Phone #: ____________________ **Work:** __________________ **Other:** ______________

Physical Address: ____

(Needed if you need any Medical Equipment, i.e., Oxygen) **Marital Status: M S D** **Are you a student? Y N**

Referring Physician: ___________________________ **PCP:** ___________________________

Emergency Contact (Not living with you): _________________________ **Phone #:** ______________

***Required Information: Race** ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Other __________ ☐ Black/African American

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Language: ☐ English ☐ Spanish ☐ Other ______________

INSURANCE INFORMATION

Primary Insurance: ____________________ **Policy #:** ________________ **Group#:** ____________

Medical Benefits #: ________________________ **Precertification #:** ________________________

Insurance Address: ____

Name of Employer that Insurance is Through____________________ **Name of Employee:** ______________

Secondary Insurance: ____________________ **Policy #:** ________________ **Group#:** ____________

Medical Benefits #: ________________________ **Precertification #:** ________________________

Insurance Address: ____

Name of Employer that Insurance is Through____________________ **Name of Employee:** ______________

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I acknowledge full financial responsibility for services rendered by Tampa Bay Pulmonary Medicine, P.A. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Tampa Bay Pulmonary Medicine, P.A. should they elect to receive such payment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

______________________ ______________________ ____________

Signature **Witness** **Date**

IVAN F. ACKERMAN, M.D., F.C.C.P.
JONATHAN P. AXEL M.D.
402 Noland Drive
Brandon, Florida 33511

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Ivan F. Ackerman, M.D., or Dr. Jonathan P. Axel, M.D. to obtain any and all medical records concerning my care from any physician, hospital or other health care profession that has provided medical care in the past. I also authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid and any insurance company, third party administrator or managed care company.

______________________________ ______________________

Patient Signature **Date**

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL INFORMATION TO INDIVIDUAL/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health Care Portability Act of 1996 (HIPPA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules be waived.

☐ I **do not** authorize the Practice to release any information concerning my medical care to any individual.

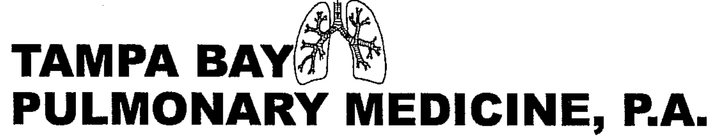
☐ I authorize the Practice to release any information concerning my medical care to the following individuals:

______________________________ ______________________________

Name/Relationship **Name/Relationship**

____________________ __________ ____________________ __________

Patient Signature **Date** **Witness** **Date**



IVAN F. ACKERMAN, M.D., F.C.C.P.
JONATHAN P. AXEL, M.D.

At your first office visit, we ask that you complete this in-depth questionnaire to the best of your ability. Though it is time consuming, it provides an excellent database for the efficient evaluation of your medical problems. If you have any questions regarding its completion, please ask the office staff.

NAME: ______________________________________

OCCUPATIONAL HISTORY:
List all jobs you have held in your life, type of work done.
Please start with your first job and end with your current or last job.

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________

HAVE YOU EVER BEEN EXPOSED TO THE FOLLOWING SUBSTANCES?
(Circle all that apply)

Acids	Chloroform	Manganese	Silica Powder
Alcohols (industrial)	Chloroprene	Mercury	Solvents
Alkalis	Chromates	Methylene Chloride	Styrene
Ammonia	Coal Dust	Nickel	Talc
Arsenic	Cold (severe)	Noise (loud)	Toluene
Asbestos	Dichlorobenzene	PBB's	Tbl or Mbl
Benzene	Ethylene Dibromide	PCB's	Trichlorethylene
Beryllium	Ethylene Dichloride	Perchloroethylene	Trinitrotoluene
Cadmium	Fiberglass	Pesticides	Vibration
Carbon Tetrachloride	Halothane	Phenol	Vinyl Chloride
Chlorinated Naphthalenes	Heat (severe)	Phosgene	X-Rays
	Isocyanates	Radiation	Welding Fumes
	Ketones	Rock Dust	
	Lead		

Are you currently employed? __________ Are you currently retired? __________
Why did you retire? (circle): Age Medical Reason Other ______________________
Which of the following do you have in your home (check all that apply):

- ☐ Air Conditioner
- ☐ Air Purifier
- ☐ Humidifier
- ☐ Gas Stove
- ☐ Electric Stove
- ☐ Fireplace
- ☐ Central Heating

Education: What was the highest grade you completed? (circle)
Elementary 1 2 3 4 5 6 7 8 High School 1 2 3 4
College 1 2 3 4 Post-Graduate ______________ Other ______________

SMOKING: Do you smoke? ________ Have you ever? ________

How many total years? ________ How many packs per day? ________

Have you quit? ________ When? ________

ALCOHOLIC BEVERAGES: Do you drink? ________ How many drinks per day? ________

Beer? ________ Wine? ________ Liquor? ________

HOUSEHOLD PETS: Do you have pets at home? ________ Indoor or outdoor? ________

Please list them (dog, cat, bird, etc.) ____________ ____________

____________ ____________

When was the last time you had the following test: (approximate date or year)

TB Skin Test ______ EKG ______ Chest X-ray ______ Breathing Test ______

MEDICATIONS: Please list medications including vitamins, aspirin, birth control pills, Tylenol, etc.

Current:	Medication Name / Strength	Reason Taken	How Often	Physician

Last 6 months:	Medication / Strength	Reason Taken	How Often	Physician

ALLERGIES: Are you allergic to any medications? What reaction do you have?

Medications: ____________________ Reaction: ____________________

____________________ Reaction: ____________________

Other allergies (eggs, dust, animals, etc.): ____________________

____

Please check appropriate space if you have had any of these illnesses:

CHILDHOOD ILLNESSES:

Rheumatic Fever ________ Mumps ________ Asthma ________

Scarlet Fever ________ Measles________ Other ________________________________

ADULT ILLNESSES:

Glaucoma	________	Stroke or Paralysis	________
High Blood Pressure	________	Diabetes	________
Stomach Ulcers	________	Arthritis	________
Hepatitis	________	Gout	________
Cirrhosis of Liver	________	Tyroid Disease	________
Colitis	________	Anemia	________
Diverticulitis	________	Tuberculosis	________
Gallstones	________	Hay Fever	________
Pancreatitis	________	Pneumonia	________
Kidney Stones	________	Pleurisy	________
Gonorrhea / Syphilis	________	Bronchitis	________
Depression	________	Emphysema	________
Nervous Breakdown	________	Heart Disease	________
Epilepsy	________	Cancer	________

HOSPITALIZATIONS AND SURGERIES: Please list all your hospitalizations and surgeries.

Date	Reason	Doctor/Hospital

FAMILY HISTORY: Father = Living ________ Age________ Illnesses ________________________

Deceased ________ Age________ Cause of Death ________________________

Mother = Living ________ Age________ Illnesses ________________________

Deceased ________ Age________ Cause of Death ________________________

List the name, living, age, and illnesses:

BROTHERS:

____

____

____

____

SISTERS:

____

____

____

____

Please check if any of your blood relatives have had any of the following:

Asthma	_______	High Blood Pressure	_______	Epilepsy	_______
Emphysema	_______	Heart Disease	_______	Cancer	_______
Bronchitis	_______	Stroke	_______	Hay Fever	_______
Tuberculosis	_______	Arthritis	_______	Anemia	_______
Diabetes	_______	Gout	_______	Other	_______

IF YOU HAVE ANY OF THESE SYMPTOMS, PLEASE PUT A CHECK BY THEM.
IF YOU ARE UNSURE PLEASE PUT A (?)

COUGH:

Do you usually cough first thing in the morning?________________

Do you usually cough after going to bed at night? ________________

Do you cough everyday for at least three months out of the year? ________________

How many years have you had this cough? ________________

Do you bring up phlegm or sputum with your cough? ________ What color? ________

How much phlegm do you usually bring up in a 24-hour period? ________________(tsp,tbsp,cup)

Have you ever coughed up blood? ________ Did you get an x-ray? ________________

WHEEZING:

Have you ever noticed whistling or wheezing in you chest? ________________

How frequently? (circle one) Daily Weekly Monthly After Colds Only

Is your wheezing more common during any particular season? ________________

Which season? ________________

Is your wheezing related to any of the following? (circle all that apply)

House Dust	Animals	Plants or Pollens
Dust or Fumes at Work	Exercise	Cigarette Smoke
Dust or Fumes at Home	Other ________________	

CHEST PAIN:

Have you ever had significant chest pain? ________________

What makes it worse? (circle all that apply)________________

Exercise	Emotional Upsets	Deep Breaths
Cough	Meals	Skipping Meals
Moving Arms		

How many years have you had this chest pain? ________________

ASTHMA:

Have you ever had asthma? ________________

Have you ever gone to the Emergency Room for your asthma? ________________

How often do you have an attack? ________________

Do you have polyps in your nose? ________________

SINUSES:

Do you frequently have post-nasal drip? ________________

Do you frequently have tenderness over you cheekbones? ________________

Have you ever had surgery on your sinuses? ________________

Have you every had the following? (check all that apply)

________ Frequently waking at night with an acid or sour taste in your mouth

________ Waking up with a sore throat in the morning

________ A burning chest pain that goes into your throat, especially when you lie down

REVIEW OF SYMPTOMS: NAME:______________________________

IF YOU HAVE ANY OF THESE SYMPTOMS, PLEASE PUT A CHECK BY THEM.
IF YOU ARE UNSURE PLEASE PUT A (?)

Weight __________ Have you gained or lost over 10 pounds in the last year? __________

SKIN
______ Chronic skin condition
______ Lump or Growth
______ Change in skin color

EYES
______ Glasses
______ Change in vision
______ Pain in eyes
______ See halo around lights

EAR
______ Trouble hearing
______ Earaches
______ Discharge from ears
______ Ringing or buzzing in ears

NOSE AND THROAT
______ Frequent sneezing
______ Nose continually stuffy or runny
______ Frequent sore throats
______ Hoarseness

BREAST
______ Lump
______ Discharge
______ Pain

HEART AND LUNG
______ Chest pain with no activity
______ Other chest pain
______ Shortness of breath
______ Sleep with more than 1 pillow to help you breathe
______ Blood in sputum
______ Wheezing
______ Unusual heartbeat
______ Heart attack
______ Swollen ankles

GENERAL
______ Loud snoring
______ Unusual fatigue
______ Swollen lymph glands
______ Fever in past month
______ Night sweats

ENDOCRINE
______ Frequent urination
______ Unusual thirst

GENITOURINARY
______ Painful urination
______ Frequent urination
______ Blood in urine
______ Discharge from vagina or penis
______ Blood or puss in urine
______ Difficulty starting urinating

MUSCULOSKELETAL
______ Painful joints
______ Sore muscles
______ Back pain
______ Unusual weakness

NEUROPSYCHIATRIC
______ Frequent or severe headaches
______ Dizziness or fainting
______ Depressed
______ Convulsions / epilepsy

LUNGS
Shortness of breath:
______ at rest
______ walking uphill or stairs
______ walking level with others your age
______ walking level at your own pace
______ washing or dressing
How far can you walk without stopping?
____
Do you exercise regularly?
What type? ____________________
How often? ____________________

STOMACH AND LIVER
______ Frequent heartburn / indigestion
______ Frequent nausea or vomiting
______ Stomach pain
______ Constipation
______ Bleeding ulcers
______ Hemorrhoids
______ Blood in bowel movements
______ Loss of appetite
______ Vomiting blood
______ Black bowel movements