SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Date: ____________________ PULMONARY PATIENT

Patient's Name____ DOB: ______________

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Social Security Number _ _ _ _ - _ _ - _ _ _

Mailing Address: ____ City ____________________________

Zip Code: _________________ State: ___________________ Email: ___________________________

Home Phone: ___________________________________ Other/Cell: ___________________________

Primary Care Physician: ______________________________________ Phone: ____________________

Referring Physician: ____ Phone: ____________________

Pharmacy Name: _______________________ City: ____________________ Phone: ___________________

EMPLOYER INFORMATION

Employer: ____ Phone: ___________________

Address: ____

INSURANCE INFORMATION

Primary Insurance: ____ ID #: ____________________

Secondary Insurance: ____ ID #: ____________________

ARE YOU THE POLICY HOLDER: Yes_________ No _________ (if no, please complete section below)

POLICY HOLDER INFORMATION

Name: ____ DOB ____________________

Address: ____

Social Security Number: ________________ Phone Number: ______________ Relationship: _____________

Employer Name: ____

Employer Address: ____

In case of Emergency, Contact: ___________________________________ Relationship: __________________

Phone: __________________

To Whom Can Medical Records be released: ____

I hereby authorize Suburban Pulmonary and Sleep Associates as a holder of Medical Information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Suburban Pulmonary and Sleep Associates and authorize Suburban Pulmonary and Sleep Associates to submit claims on my behalf for any bills or services furnished to me during the next 12-month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

Signature ____ Date ___________________________

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Patient Name: ____ DOB ________________

AUTHORIZATION FOR TREATMENT

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the Physician and/or his Healthcare providers.

RELEASE OF INFORMATION

I authorize the facility to release to my insurance carrier or its designated agents any information concerning medical care (physical or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of valid as the original. I will notify the facility in writing of any information I do not want released.

ASSIGNMENT OF INSURANCE BENEFITS

I authorized the assignment of benefits payable to Suburban Pulmonary and Sleep Associates, LTD, and/or its designees for Physician services and supplies by government and or any other private third party payer. I understand I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

FINANCIAL POLICY

- **Co-payments are required to be paid at the time of check in for your appointment. If you are unable to pay at the time, your appointment will be rescheduled.**
- **Self-Pay accounts are required to be paid at the time of check-out after your office visit has been completed. All services that were provided at the time of service must be paid in full.**
- **Insurance: our office will bill all insurance companies for the services provided. Upon response of insurance, you will be sent a statement stating your payment responsibility. Our office requires balances to be paid within 30 days of receiving the billing statement.**

I agree to pay any outstanding balances within 30 days after receiving a statement from Suburban Pulmonary and Sleep Associates, LTD, notifying me of such balance.

ADDITIONAL FEES

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may occur.

RECEIPT OF NOTICE OF PRIVACY PRACTICES FROM

I HEREBY ACKNOWLEDGE receipt of the Physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the Practice may use and disclose my confidential information. I understand that the Physician has reserved a right to change his or her privacy Practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available for any review at all Suburban Pulmonary and Sleep Associates, LTD, locations.

______________________________________ ______________________________________

Signature of Patient/Guarantor **Print Name of Patient/Guarantor**

Date Signed ______________________________

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Patient Name: ____ DOB ______________

ALLERGIES

☐ **NO KNOWN ALLERGIES**

LIST ANY MEDICATION ALLERGIES OR ADVERSE REACTIONS:

DRUG	REACTION

MEDICATIONS

Please list all medicines that you are CURRENTLY taking:

MEDICATION	DOSE	FREQUENCY		MEDICATION	DOSE	FREQUENCY

IMMUNIZATIONS

IMMUNIZATION	DATE of MOST RECENT
Influenza/Flu	
Pneumovax	
Prevnar 13	

Date Completed: ______________________________

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Patient Name ____DOB __/__/____

Marital Status: Single/ Married/ Widowed/ Divorced

Work Status: Full time/ Part time/ Self-Employed/ Retired/ Other____________

Reason for Visit ____

Social History (Check all items that apply)

	No	Yes	If yes, fill out below
Do you currently smoke?			Type_____________________________ Average packs per day_________________ Number of years smoked total_____________
Did you smoke in the past?			Year quit__________________ Average packs per day_________________ Number of years smoked total_____________
Do you use recreational drugs?			Type of drug________________ Date last used________________
Do you drink alcoholic beverages? Have you ever been treated for dependency?			Type of alcohol_______________ Average per day ______________
Do you use caffeine? (Coffee, soda, Tea, Pills)			Type of caffeine_____________ Average per day_____________
	No	Yes	
When was your last TB skin test?			N/A _______ Date ___/___/____ Results: ☐ Positive ☐ Negative

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Patient Name____**DOB**_____________

PAST MEDICAL HISTORY:

	YES			YES
No significant Medical History			Heartburn	
Arthritis			Kidney Disease	
Asthma			Narcolepsy	
Atrial Fibrillation			Parkinson's Disease	
Blood Clots (legs, lungs, other)			Pulmonary Fibrosis	
Cancer (type_______________)			Pulmonary Hypertension	
Congestive Heart Failure			Sarcoidosis	
COPD/Emphysema			Seizures	
Coronary Artery Disease			Sinus Disease	
CAB Surgery Date_______________			Sleep Apnea	
CAD Heart Attack Date __________			Stroke	
CAD Stent Date ________________			Thyroid Disease -Overactive (Hyper)	
Diabetes (Type I or II)			Thyroid Disease -Underactive (Hypo)	
Fibromyalgia			Other:	
High Blood Pressure				

FAMILY MEDICAL HISTORY (CHECK ALL ITEMS THAT APPLY)

	YES			YES
No significant Family History			High Blood Pressure	
Asthma			Narcolepsy	
Blood Clots (legs, lungs, other)			Pulmonary Hypertension	
Cancer (type_______________)			Sleep Apnea	
COPD/Emphysema			Thyroid Disease -Overactive (Hyper)	
Coronary Artery Disease			Thyroid Disease -Overactive (Hypo)	
Diabetes (Type I or II)			Other:	
Emphysema				

PAST SURGICAL HISTORY (PLEASE LIST SURGERIES AND YEARS PERFORMED)

TYPE OF SURGERY	DATE		PROSTHESIS/ASSISTIVE DEVICES	YEAR
			Artificial Heart Valves	
			Artificial Joints	
			Dentures (Upper/Lower)	
			Defibrillator	
			Pacemaker	
			Walker/Cane/Wheelchair	
			Other:	

Date Completed: ____

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

Patient Name____**DOB**____________

Check all items that are existing or current complaints

Head/Eyes/Ears/Nose/Throat Complaints(HEENT)

- ☐ **No** HEENT Complaints
- ☐ Hearing Loss
- ☐ Cataracts
- ☐ Itching, Burning, or Dry Eyes
- ☐ Voice Changes/Laryngitis
- ☐ Nosebleeds
- ☐ Hay Fever
- ☐ Postnasal Drip
- ☐ Sinus Congestion
- ☐ Sinus Headaches
- ☐ Other ____________________________

Musculoskeletal/Skin Complaints

- ☐ **No** Musculoskeletal/Skin Complaints
- ☐ Rashes/Bruises/ Sores
- ☐ Muscle Pain
- ☐ Joint Pain/Swelling/Deformities
- ☐ Chronic Pain/Stiffness
- ☐ Back Pain
- ☐ Other____________________________

Neurological Complaints

- ☐ **No** Neurological Complaints
- ☐ Headache
- ☐ Seizures
- ☐ Weakness/Tingling/Numbness
- ☐ Fainting Spells
- ☐ Dizziness
- ☐ Other___________________________

Cardiovascular Complaints

- ☐ **No** Cardiovascular Complaints
- ☐ Chest Pain/Angina
- ☐ Irregular Heart Rhythm/Palpitations
- ☐ Heart Murmur
- ☐ Swelling of ankles/Edema
- ☐ Short of breath lying flat
- ☐ Leg Cramps -Walking/Rest/Sleep
- ☐ Other__________________________
- ☐ Choking Feeling

Respiratory Complaints

- ☐ **No** Respiratory Complaints
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other_________________________

Gastrointestinal Complaints

- ☐ **No** Gastrointestinal Complaints
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Heartburn or reflux symptoms
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool/bloody stool
- ☐ Other__________________________

Endocrine/Other Complaints

- ☐ **No** Endocrine Complaints
- ☐ Increased thirst
- ☐ Intolerant of heat
- ☐ Intolerant of cold
- ☐ Chronically tired or fatigued
- ☐ Low blood count or anemic
- ☐ Other_________________________

Genitourinary Complaints

- ☐ **No** Genitourinary Complaints
- ☐ Prostate Problems
- ☐ Incontinence during sleep
- ☐ Incontinence while coughing
- ☐ Other______________________________

General Complaints

- ☐ **No** General Complaints
- ☐ Chills
- ☐ Fevers
- ☐ Sweats
- ☐ Weight gain in past year _______lbs
- ☐ Weigh loss in past year ________lbs
- ☐ Loss of appetite

Other______________________

Date Completed: _________________________________

PULMONARY QUESTIONNAIRE/H&P

Patient Name: ____ **DOB** _______________

PULMONARY QUESTIONNAIRE/H&P

Patient Name: ____ DOB ________________

	NO	YES
1. Do you have shortness of breath? If yes, How long____ How far can you walk before you feel short of breath? ________feet ______blocks How many stairs can you climb before feeling short of breath? ____flights of stairs What activities of daily living cause shortness of breath? _________________ ____		
2. Do you cough? If yes, How long ____ Does anything make it worse? ____ Does anything make it better? ____ Does it occur at a particular place? ______________________________________ Does it occur at a certain time of day? ___________________________________ Does it occur at a certain time of year? __________________________________		
3. Have you ever coughed up blood? If yes, date of last episode ____		
4. Do you have any pains in your chest? If yes, How long ____ Does anything make it worse? ____ Does anything make it better? ____		
5. Do you wheeze? If yes, How long ____ Does anything make it worse? ____ ☐ Cold Air ☐ Exercise ☐ Perfume ☐ Smoke ☐ Other ________________________ Does anything make it better? ____ Does it occur at a particular place? ______________________________________ Does it occur at a particular time of day? _________________________________ Does it occur at a particular time of year? ________________________________		
6. Have you ever had pneumonia?		

SUBURBAN PULMONARY AND SLEEP ASSOCIATES, LTD.

PULMONARY QUESTIONNAIRE/H&P CONT'D		
	NO	**YES**
7. Do you have pets? (including birds) If yes, What type of pets? ___		
8. Do you have sinus problems?		
9. Do you have asthma? If yes, How often do you have attacks per year? ___ Have you required an emergency room visit for an attack? ___If yes, Date of last ER visit ___ Number of visits in last 2 years ___		
10. Have you ever been in Intensive Care Unit for a lung problem?		
11. Have you ever been on a ventilator (breathing machine)? If yes, Date: ___		

Completed by: ___ **Date** ___

Provider Signature: ___ **Date** ___