SOUTHEAST LUNG ALLIANCE

Lung Cancer: Prevention, Early Detection, Cure

Center for Cancer Care
One Hospital Drive, Ste 100
Huntsville, AL 35801
(256) 327-5885

Clearview Cancer Institute
3601 CCI Drive
Huntsville, AL 35805
(256) 705-4266

Heart Center, Inc.
930 Franklin St SE
Huntsville, AL 35801
(256) 539-4080

Huntsville Cardiothoracic Surgeons
201 Sivley Road SW Ste 300
Huntsville, AL 35801
(256) 536-5594

Huntsville Hospital
101 Sivley Road
Huntsville, AL 35801
(256) 265-1000

Huntsville Hospital Lung Center
930 Franklin Street, Ste 101
Huntsville, AL 35801
(256) 265-5864

Huntsville Lung Associates
600 St. Clair Avenue
Bld. 8, Ste 22
Huntsville, AL 35801
(256) 533-6003

Interventional Radiology Clinic
Huntsville Hospital Dept. of Radiology
101 Sivley Road
Huntsville, AL 35801
(256) 265-8300

P-athology Associates
2904 Westcorp Blvd SW
Huntsville, Al 35805
(256) 533-1480

Pulmonary & Sleep Associates of
Huntsville, PC
725 Madison Street
Huntsville, AL 35801
(256) 883-2112

Spine & Neuro Center
201 Governors Dr. SW
Huntsville, AL 35801
(256) 533-1600

The Cancer Center of Huntsville, PC
201 Governors Dr, Ste 320
Huntsville, AL 35801
(256) 265-1822

PATIENT INFORMATION: Date:_____

Last Name:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip:_____

DOB:_____ SS#:_____ Phone:_____

Email Address:_____ Marital Status:_____

Preferred Language:_____ Ethnicity:_____

Race:_____ Employer:_____

Employer Address:_____

Employer Phone:_____ Occupation:_____

Employee Status:_____ Retirement Year:_____

Date Updated:_____ Spouse/Guardian:_____

DOB:_____ Cell Phone:_____ Day Phone:_____

Night Phone:_____ Email:_____

EMERGENCY CONTACT INFORMATION:

Emergency Contact:_____

Night Phone:_____ Address:_____

City:_____ State:_____ Zip:_____

Relationship to Patient:_____ Day Phone:_____

Emergency Contact:_____

Night Phone:_____ Address:_____

City:_____ State:_____ Zip:_____

Relationship to Patient:_____ Day Phone:_____

GUARANTOR INFORMATION ("responsible party"):

Name:_____ DOB:_____

SS#:_____ Gender:_____ Night Phone:_____

Address:_____

Relationship to Patient:_____ Date Updated:_____

Employer:_____ Occupation:_____

Employer Address:_____

Employer Phone:_____ Employee Status:_____

Retirement Year:_____

Physician:_____ Patient:_____

INSURANCE INFORMATION:

Primary Insurance:_____ Policy #: _____

Name of Policyholder/Insured:_____

Group #:_____ Insured DOB:_____ Copay:_____

Insured Relationship to Patient:_____ PCP Referral #:_____

Effective/Expiration Date:_____ Override Name:_____

Insurance Company Address:_____

Secondary Insurance:_____ Policy #: _____

Name of Policyholder/Insured:_____

Group #:_____ Insured DOB:_____ Copay:_____

Insured Relationship to Patient:_____ PCP Referral #:_____

Effective/Expiration Date:_____ Override Name:_____

Insurance Company Address:_____

Other Insurance:_____ Policy #: _____

Name of Policyholder/Insured:_____

Group #:_____ Insured DOB:_____ Copay:_____

Insured Relationship to Patient:_____ PCP Referral #:_____

Effective/Expiration Date:_____ Override Name:_____

Insurance Company Address:_____

RELEASE INFORMATION:

I authorize release of information relative to my medical records and/or lab results realted to Alliance for Lung Cancer Excellence to:

List Person(s)

_____ _____

Patient or Authorized Person's Signature Date

NAME OF INSTITUTION OR DOCTOR FROM WHICH MEDICAL INFORMATION IS TO BE OBTAINED:

AUTHORIZATION TO PAY

I hereby authorize payment directly to the physicians associated with Alliance for Lung Cancer Excellence, of the medical and/or emergency medical benefits, including major medical insurance, if any, otherwise payable to me for this service as described below. I understand that I am financially responsible for the charges not covered by this authorization.

Signed (Responsible Party):_____

Signed (Insured):_____

Date:_____

Physician:_____ Patient:_____

Physicians involved in my care:

Referring Physician:_____ Other Physicians:_____

Family Physician:_____ _____

Cardiologists:_____ _____

Chief Complaint or reason for initial visit:_____

What tests (date and location) have already been done?

Test(s)	Date	Location

Past Surgical History: ☐ NONE

	Year	Type Surgery	Institution
CHEST			
ABDOMEN			
ORTHOPEDIC			
OTHER			

Past Medical History: (check all that apply)

Cardiovascular Disease:
- ☐ BLOOD CLOTS
- ☐ CORONARY DISEASE
- ☐ HYPERTENSION
- ☐ OTHER HEART DISEASE

Gastrointestinal:
- ☐ ACID REFLUX
- ☐ GI BLEEDING
- ☐ LIVER DISEASE
- ☐ OTHER

Pulmonary Disease:
- ☐ ASTHMA
- ☐ COPD
- ☐ SLEEP APNEA
- ☐ TUBERCULOSIS
- ☐ OTHER

Neurological:
- ☐ SEIZURES
- ☐ STROKE
- ☐ TIA
- ☐ OTHER

Metabolic:
- ☐ DIABETES
- ☐ THYROID DISEASE
- ☐

Other:
- ☐ ARTHRITIS
- ☐ CANCER
- ☐ KIDNEY DISEASE

Other:_____

☐ NONE

Review Of Systems:

General:
- ☐ CHILLS
- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ NIGHT SWEATS
- WEIGHT LOSS, _____

Neurological:
- ☐ LOSS OF CONSCIOUSNESS
- ☐ ONE SIDED WEAKNESS
- ☐ PROBLEM WALKING

Hematology:
- ☐ BLEEDING
- ☐ BRUISING
- ☐ ENLARGED NODE

Gastrointestinal:
- ☐ DIFFICULTY SWALLOWING
- ☐ INDIGESTION

Heart:
- ☐ CHEST DISCOMFORT
- ☐ RACING/SKIPPING HEART BEATS

Urinary:
- ☐ DIFFICULTY URINATING
- ☐ FREQUENT URINATION AT NIGHT

Lungs:
- ☐ COUGH
- ☐ PLEURISY
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH

Skeletal:
- ☐ JOINT PAIN

Skin:
- ☐ ITCHING
- ☐ RASH
- ☐ ULCERS

Sleep:
- ☐ DAYTIME SLEEPINESS
- ☐ EXCESSIVE SNORING

Physician:_____ Patient:_____

Family History:

	Age	Serious Health Problems (Heart Disease, Cancer, Stroke)	Cause of Death
Father:			
Mother:			
Sibling:			
Sibling:			
Other:			
Other:			

Vaccination History/ Skin Tests: (year taken)

☐ Influenza, year:_____ ☐ Pneumonia shot, year:_____ ☐ TB Skin Test, year:_____

Current Medications: (prescription, over the counter, vitamins, & herbs)

Medication	Dose	Route	How Often	Reason	Date Last Taken

Are you on/have taken blood thinners? ☐ No ☐ Yes Date last taken:_____

Allergies (include drugs, food, and environmental allergies) :

I am allergic to: I have this reaction:

1) _____

2) _____

3) _____

Any Latex/Rubber Allergy: ☐ NO ☐ YES X-Ray Dye Allergy: ☐ NO ☐ YES

Social History:

Do you now or did you ever smoke cigarettes or cigars? ☐ NO ☐ YES

If Yes: Age when you started smoking? _____ Age when you quit smoking?_____

How many packs/day do (did) you smoke? _____ Are you interested in quitting ? ☐ NO ☐ YES

Do you drink alcohol? ☐ NO ☐ YES If yes , # of drinks per week?_____

What is (was) your occupation? _____

Have you had any toxic exposures? ☐ NO ☐ YES

If yes, what substances:

☐ ASBESTOS ☐ RADIOACTIVE MATERIAL ☐ ETHYLENE DIAMINE ☐ PLATINUM, NICKEL, COBALT ☐ OTHER

Do you have an advanced directive (Living Will)? ☐ NO ☐ YES

If yes , would you like to have it as part of your record? ☐ NO ☐ YES

Is there anything that has not been asked that you would like to describe?

_____

_____

The information provided is accurate to the best of my knowlegde

_____

Person completing form & relationship if other than patient Date Time

Physician:_____ Patient:_____