# Pulmonary & Critical Care Associates, L.L.C.

Referred By: Dr. / Friend______________________________
(Name)

PATIENT INFORMATION

Name: ________________________________________ Date of Birth:______________________

Address:__________________________________________ Marital Status:_____________________

City, State, & Zip:_______________________________________ S.S. No.:___________________________

Phone Number (home): _______________________________ (cell) _______________________________

EMPLOYMENT INFORMATION

Employer:____________________________________ Occupation:_______________________

Address: _____________________________________ Phone #:__________________________

City, State & Zip:______________________________

INSURANCE INFORMATION

Insured:______________________________________ Date of Birth:______________________

Insured's Employer:____________________________ Occupation:_______________________

**Emergency Contact (other the Spouse)**

Name: ________________________________________ Relation:__________________________

Address:__________________________________________ Phone #:__________________________

**Assignment of Insurance Benefits**

I hereby authorize direct payment of surgical/medical benefits to Pulmonary & Critical Care Associates for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

__________________________________________
Patient's Signature

**Authorization to Release Information**

I hereby authorize Pulmonary & Critical Care Associates to release any medical or incidental information that may be necessary to either medical care or in processing applications for financial benefit.

__________________________________________
Patient's Signature

**Medicare-Medicaid**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient's Name:______________________________
HIC Number:________________________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pulmonary & Critical Care Associates for any services furnished me by a physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits payable for related services.

Patient's Signature__________________________________ Date:_______________

NOTICE OF PRIVACY PRACTICE RECEIVED:__________________________________ Date:__________
Patient's Signature

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# OFFICE POLICY ON MANAGED CARE AND OTHER THIRD-PARTY PAYORS (INSURERS)

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs and continue to accept and participate in other insurance plans.

Well informed patients receive the best benefits from their insurance company. Your insurance company may require you to provide us with a referral prior to making an appointment. You are responsible for getting the referral from your primary care physician. If you have any questions regarding your benefits or a referral the best source of information is the member services phone number located on your insurance identification card.

While we are pleased to be able to provide this service to you, it is very difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon the type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines, if you let us know at EACH time of service exactly what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contact and we subsequently order or perform services that are not covered, ,such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I have read and fully understand the office policy stated above and agree to accept responsibility for payment in full of all non-covered services and/or medical supplies.

Signature: ____________________________________ Date:_________________________

# Pulmonary & Critical Care Associates, L.L.C.

Name:_________________________________ Date:___________________________

**Briefly describe your present symptoms**:___________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Medications:**

**Drug Allergies**:________________________

Please list any present medications you are currently taking:

Name of Drug Dosage # of times taken daily started when
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**PAST PERSONAL HISTORY**

Do you or have you had: (Check if yes)

Cancer ☐
Leukemia ☐
Epilepsy ☐
Bad Headaches ☐
Pneumonia ☐
Tuberculosis ☐
Heart Problems ☐
Stroke ☐
Nervous Breakdown ☐
Jaundice ☐
Bronchitis ☐
Psoriasis☐
Asthma ☐
Cataracts ☐
Stomach Ulcers ☐
Colitis ☐
Sleep Apnea ☐
Anemia ☐
Goiter ☐
Diabetes ☐
Rheumatic Fever ☐
Kidney Disease ☐
Emphysema ☐

Other significant illness:_______________________________________________________________

**SURGICAL HISTORY**

Type Year Hospital/Surgeon
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Any other serious injuries?________ if yes, describe_________________________________________

**FAMILY HISTORY**

Do you know of any blood relative with has or had: (check and give relationship)

Cancer ☐____________Heart Disease ☐_________________Rheumatic Fever ☐________________
Tuberculosis ☐______________ Leukemia ☐_______________ Hypertension ☐_________________
Epilepsy ☐______________Diabetes ☐___________________ Stroke ☐________________________
Bleeding tendency ☐____________Asthma ☐___________________Goiter ☐___________________
Colitis ☐_________Alcoholism ☐________Infectious Disease ☐________Thyroid Disease ☐_______

**TRAVEL HISTORY**

USA or Foreign________________________________________________________________________

**SOCIAL HISTORY**

| | Yes | No | When Started | When Stopped | |
|---|---|---|---|---|---|
| Cigarettes | ☐ | ☐ | _____________ | _____________ | Packs a day____________ |
| Coffee/Tea/Cola | ☐ | ☐ | _____________ | _____________ | Cups a day____________ |
| Alcohol | ☐ | ☐ | _____________ | _____________ | Amount________________ |
| Other Drugs | ☐ | ☐ | _____________ | _____________ | Name_________________ |

**MEALS:**

Regular? Yes☐ No☐ Number of Meals a day_______ Snacks per day__________

**EXERCISE:**

None ☐ Irregular☐ Regular☐ Type/Frequency______________________

## Systems Review:

(as you review the following, please check any of those problems which apply to you.)

**General:**
- ☐ Recent weight loss/amount____
- ☐ Recent loss of weight/ amount____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever/Chills

**Nervous System**
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle Spasms
- ☐ Loss of Consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory Loss

**Ears:**
- ☐ Ringing in ears
- ☐ Loss of hearing

**Eyes:**.
- ☐ Cataract Surgery
- ☐ Glasses
- ☐ Glaucoma

**Nose:**
- ☐ Nosebleeds/Dryness
- ☐ Loss of smell
- ☐ Post Nasal Drip
- ☐ Nasal Congestion/Stuffiness

**Mouth**:
- ☐ Bleeding gums/Sores in mouth
- ☐ Dryness
- ☐Loss of Taste

**Neck**:
- ☐ Swollen glands

**Heart & Lungs**
- ☐ pain in chest
- ☐ Irregular heart beat
- ☐ Shortness of Breath
- ☐ Difficulty Breathing at night
- ☐ Swollen legs/feet
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing
- ☐ Night Sweats

**Stomach & Intestine**
- ☐ Nausea
- ☐ Vomiting of blood
- ☐ Reflux
- ☐ Yellow jaundice
- ☐ Increasing Constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools/Black Stool
- ☐ Heartburn

**Throat**
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

**Sleep:**
- ☐ Snoring
- ☐ Daytime Sleeping
- ☐ Wake from sleep to urinate
- ☐ Wake from sleep choking
- ☐ Morning Headache

**Skin:**
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash/Hives

- ☐ Sun sensitive
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss

**Muscle/Joints/Bone:**
- ☐ Morning Stiffness
- ☐ Muscle Weakness
- ☐ Muscle Tightness
- ☐ Joint Pain
- ☐ Joint Swelling

**Blood:**
- ☐ Anemia
- ☐ Bleeding tendency

**Kidney/Bladder:**

Any problems with urination or bowel movements? __________
_____________________
_____________________
_____________________
_____________________
_____________________
_____________________
_____________________
_____________________
_____________________
_____________________
_____________________