Chest Medicine of Cullman
Pulmonary Diseases ▪ Sleep Disorders ▪ Critical Care Medicine
Prehospital/EMS, Tactical & Disaster Medicine
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Pulmonary and Sleep Disorders Clinic

NEW PATIENT DATA

All information will be kept strictly confidential
Please fill in with black or blue ink pen.

Before your first visit, please visit our website**,**
***www.ChestMedicine.us* and log in to your Patient Portal!**

***PATIENT DATA** Today's date_____

Full Name _____

Preferred/Nickname if any_____

DOB ____-_____-_____ SSN _____-_____-_____ Gender: ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____

Cell Phone (____)_____ E-mail Address : _____@_____

Employer _____

☐ Retired ☐ Disabled Date _____ Disability Reason: _____

Spouse/Parent/Guardian Name _____

Phone (_____)_____ Spouse's DOB _____

Address _____ Spouse's Employer _____

Emergency Contact:
Name _____ Relation _____ Phone _(_____)_____

What Pharmacy do you use? _____ 90 day supply on meds? Y N

***INSURANCE**

Primary Carrier _____ Policy # _____

Subscriber Name _____ Group # _____

Secondary Insurer _____ Policy # _____

Subscriber's Name _____ Group # _____

Primary Care Physician's Name _____ City _____

Referring Physician's Name _____ City _____

Who is completing this form? ☐ Myself (patient) ☐ Friend/Relative - Who?_____

Do you have living will/advance directive? ☐Yes ☐No Do you have difficulty reading/writing? ☐Yes ☐ No

***PAST MEDICAL HISTORY**

*List diseases and dates diagnosed. If you take **any** medications, you must list a reason here.*

***SURGERIES**

List all surgeries and the dates that they occurred. Attach separate sheet if necessary

***CURRENT MEDICATIONS**

List all medications and doses (don't forget eyedrops ,over-the-counter meds/herbs, inhalers and oxygen).List reason for each above.

***DRUG ALLERGIES**

*List any medications that you cannot take or are allergic to, state **What the bad effects are** when these medications are taken.*

1) _____ 2) _____

3) _____ 4) _____

***FAMILY HISTORY** Relative	Age Now If still Living	Health Problems	Age at Death	Disease/Cause of Death
Father _____	_____	_____	_____	_____
Mother _____	_____	_____	_____	_____
Brothers/Sisters _____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Children _____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What is your **main complaint**? What do you expect to achieve from this evaluation?

PERSONAL HISTORY:

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Occupation: *List current if any and Past*_____

Exposures: Exposed to dangerous **Substances** at work (list i.e., asbestos, silica, chemicals) or **Tuberculosis**

List: _____. Approx. Date of last **Pneumonia vaccine**: _____or ☐never

Less than 2 mo. ago travel overseas/3rd world: ☐No ☐Yes – *List* _____ Indoor pets: ☐No ☐Yes – *List* _____

Tobacco: ☐ Current Smoker of ____ packs per day for _____ years

☐ Past Smoker of ____ packs per day for _____ years. I quit _____ years ago.

☐ Exposed to heavy secondhand smoke ☐ currently and/or ☐past , when did it end?_____

☐ I Never smoked ☐ smokeless tobacco- now or past ? _____

Alcohol: ☐ Current alcohol use of _____ drinks per day

☐ Prior heavy alcohol use - quit _____ years ago

☐ Never drank

Blood transfusions: ☐ None ☐ Yes, if so, when? ____ **Caffeine**: _____ cups of coffee/tea/cola per day.

Street Drug Use: ☐ Never ☐ Past ☐ Present –circle or List name(s) past & present: i.e.Marijuana/Cocaine/Meth, pain pills, *other drugs* _____

Religion: _____ Church attending: _____

Many patients would like to know God better. *Would you like to know God personally*? _____

SYMPTOMS: *Circle or List any problems that you are *currently* having with the following:

Energy, loss of appetite: _____ Unintentional Weight gain *or* loss(circle which): ____ lbs. over last ___ months

Eyes, ears, allergies, hoarseness, sinuses, nasal drainage: _____

Are you **short of breath**? ☐ No ☐Yes, it is: ☐at rest ☐with exertion ☐unpredictable attacks

Do you **cough** often? ☐No ☐Yes, it is: ☐dry ☐wet/mucus ☐nighttime ☐bloody ☐worse with exercise ☐**wheezing**.

Have you ever had a abnormal **TB skin test**? N Y when?_____ Were you treated? Y N Do you have an **ozone generator?** Y N

List other problems with your lungs, chest, or breathing: _____

Heart disease, poor circulation, uncontrolled blood pressure, ankle/leg swell_____

Heartburn, ulcers, hernia, diarrhea, constipation, choking on food/drink:_____

Kidneys, urine, sexual function, abnormal gyn bleeding or discharge: _____

Rash, blood sugar, thyroid, lymph nodes, current cancers, bleeding, clotting, anemia::_____

Frequent Infections/fevers, HIV risk factors, night sweats: _____

Arthritis, back, fibromyalgia, gout, RA, osteoporosis: _____

Mood, depression, anxiety, suicidal now, mental health_____

Insomnia, snoring, daytime sleepiness, Previous sleep study, CPAP_____

Memory, strokes, shakes, numbness, headaches, restless legs: _____Other*(list)*_____

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGMENT

Your health care provider and health plan must give you a notice that tells you how they may use and share your health information and how you can exercise your health privacy rights called a notice of privacy practices. Chest Medicine of Cullman is dedicated to protecting the privacy of each and every patient. It is your right to receive quality care without concerning her personal health information (PHI) will be shared was closed others. Your medical information is protected by law and will only be used in treatment, payment and healthcare operation scenarios. Employees of Chest Medicine of Cullman and affiliated business associates have signed confidentiality statements and contractural agreements agreeing to follow the policies and procedures of our practice in protecting your privacy. While disclosures of personal health information to doctors, nurses, pharmacists, medical equipment providers and specialists is often necessary for treatment, your medical information will not be sold to any outside agency, pharmaceutical company nor will it be released for any reason other than treatment, payment, healthcare operations or when required by state or federal laws without your written authorization. Other uses and disclosures of medical information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law. You have a right to access and request changes to your medical record, find out what disclosures have been made, and request restrictions on uses and disclosures of your health information. At a time you have questions or concerns you may contact our Compliance Officer at 256-737-8047 or file a complaint with HHS if you believe your privacy rights have been violated. If you file a complaint, we will not take any action against you or change our treatment of you in any way. This privacy notices subject to change. Signing does not mean that you have agreed to any special uses or disclosures of your health records. Refusing to sign this acknowledgement does not prevent us from using or disclosing health information as the Rule permits us to do. You have the right to a paper copy of this Notice at any time. Copies of this Notice are also available at our website, http://www.ChestMedicine.us. By signing below, I am acknowledging that: I am either the patient or the patient's personal representative; I have received a copy of the "Notice of Privacy Practices" for Chest Medicine of Cullman; and I understand that I may contact the person named in the Notice if I have questions about the content of the Notice. **Signing this statement acknowledges that you have been provided with a copy of our privacy practices policy.** List Names and relationships of Anyone (i.e. spouse, child) that may contact us about your appointments, tests or treatment: _____ _____ _____or ( ) No one *Initial Here:* _____

INFORMED CONSENT

FOR PULMONARY DIAGNOSTIC TESTING-During your evaluation and treatment, commonly performed tests include pulmonary function tests that measure the amount of air you have in your lungs and how well you can move that air by forcefully blowing into a lung function machine, before and after treatment with a bronchodilator, and sometimes walking for 6 minutes. This may make me short of breath for a little while. You may be given methacholine which can cause symptoms of asthma including shortness of breath and wheezing. You may also have arterial blood gases. In this study we will draw blood with a needle from one of your arteries in your arm or wrist to see how well your lungs move oxygen into your bloodstream and take carbon dioxide out. We may give you a small amount of numbing medicine to reduce the pain before we put the needle in. There is sometimes pain, bleeding, and occasionally clotting of the artery, causing the hand to not receive adequate blood which can cause serious and rarely permanent disability. I understand that I have been informed of the risks, alternatives and benefits of this procedure and I give my permission for the test(s) to be performed and all of my questions have been answered before doing so. *Initial Here:* _____

TO CONTACT CONSUMER BY CELL PHONE- You agree, in order for us to service your account or to collect monies you may owe, Chest Medicine of Cullman/Cullman Internal Medicine, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We also may contact you by sending text messages or emails using any email address you provide to use. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/we have read this disclosure and agreed to Cullman Internal Medicine, PC, and its employees or agents may contact me us as described above. *Initial here* _____

AUTHORIZATION TO BILL INSURANCE/STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Chest Medicine of Cullman to furnish to the listed insurance company(ies) all information which that insurance companies may request. I hereby assign to Cullman Internal Medicine, PC, all money to which I'm entitled for medical /surgical expenses relative to the service rendered but not to exceed my indebtedness to the professional corporation. I understand that I'm financially responsible to the said Corporation for charges not covered by this assignment. Section 1862 (a) (1) of Medicare law states that Medicare will only pay for services that it determines our "reasonable and necessary." If the services are determined not to be "reasonable and necessary" by Medicare program standards, payment will be denied. I further agree in the event of nonpayment, to bear the cost of collection, and/or Court cost and responsible legal fees. I also understand and accept liability for additional fees that I alone am financially responsible for and are not paid for by my insurance such as co-pays; and fees that are not part of my insurance contract- these may include medical records copying fees, No show charges ($25 if you fail to keep a scheduled appointment) and fees for exhaustive paperwork (such as disability determination).

Signature of Patient (or parent/legally responsible person): _____Date: _____