

# Lung, Allergy & Sleep MEDICINE CENTER

27901 Woodward Avenue  
Suite 220  
Berkley, MI 48072

Ph: 248.556.5582

Fax: 248.850.7142

Email: psmcenter@gmail.com

## PATIENT DEMOGRAPHICS

TODAY'S DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL INFORMATION: \_\_\_\_\_

EMERGENCY CONTACT NAME AND PHONE #: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_

PHARMACY ADDRESS: \_\_\_\_\_

PHARMACY PHONE #: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

ARE YOU USING OXYGEN OR NEBULIZER? YES OR NO. IF YES, FOR HOW LONG \_\_\_\_\_

ARE YOU USING CPAP MACHINE? YES OR NO. IF YES FOR HOW LONG \_\_\_\_\_

NAME OF DURABLE MEDICAL SUPPLY COMPANY FOR MEDICAL SUPPLY NEEDS (DME):  
\_\_\_\_\_

**NAME(S) OF PERSON(S) THAT MAY RETRIEVE ANY MEDICAL INFO AND/OR RECORDS FOR  
PATIENT AND THE RELATIONSHIP TO PATIENT:**  
\_\_\_\_\_

**SIGNATURE AND DATE:** \_\_\_\_\_



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## INSURANCE WAIVER/AGREEMENT

### PLEASE BE ADVISED:

It is your responsibility as a patient to alert the office staff prior to your scheduled appointment of **ANY** insurance changes; contract ID's, new insurance company, etc.

**Please note:** It is also your responsibility as patient to check with your insurance company to determine whether a referral/authorization for your office visit or testing being performed in our clinic is indeed required to assure coverage for yourself by your insurance company. This is not the office staff's responsibility to determine for you.

Should a referral/authorization is required and is not obtained or any other charges is not covered by insurance, the charges incurred will be patient's responsibility.

We must emphasize that our relationship is with you and not your insurance carrier. Your insurance is a contract between you, your employer and your insurance carrier. We are not party to that contract. All charges are your responsibility from the date(s) of services rendered.

I have read and understand this policy and agree by signing below:

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## CONSENT FORM

I authorize Lung Allergy & Sleep Medicine Center to request for medical records on my behalf.

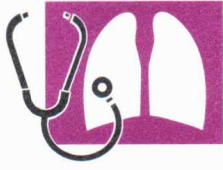
I authorize \_\_\_\_\_ to request medical records on my behalf.

\_\_\_\_\_

(Patient Name)

\_\_\_\_\_

(Patient Signature and Date)



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**Consent to the use and disclosure of health information for treatment, payment, or other healthcare operations.**

Your health information privacy rights include:

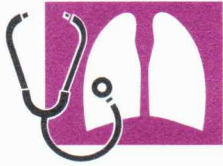
- You can ask to get a copy of your medical record. You may request in writing and pay for the cost of copying and mailing
- You can ask to change/add information ,if you think something is missing or incomplete
- You have the right to request that our practice communicate with you about your health information in a particular manner or location

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans of my future health care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among all health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that the practice will use and disclose my information when required to do so by Federal, State or Local Law. I understand the practice may release my information for workers compensation and similar programs. I understand that the practice reserves the right to change their notices and practices and prior to implementation will mail a copy of any revised notice to the address provided. I understand that I have the right to object the use of my health information for directory purposes. I have the right to request restrictions for how my information may be used or disclosed. I understand that I may revoke this consent in writing, except to the extent that the practice has already take action in reliance thereon.

Signature of patient or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_



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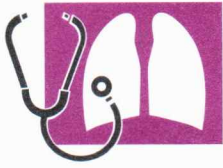
Ph: 248.556.5582

Fax: 248.850.7142

Email: [psmcenter@gmail.com](mailto:psmcenter@gmail.com)

## OFFICE POLICIES

- **COPAYS:** All copays are due at the time of service, should you choose for your copay to be billed to you instead, it is our obligation to inform you that you will then be charged an additional \$5.00 fee.
- **ALL CANCELLATIONS** without a 24 hour notice will incur a \$50.00 fee for missed appointment. You can call the office at 248-556-5582 or leave a message with the answering service if you can not make it to the appointment.
- **PATIENT CHECK-IN:** You will be asked at every visit for your medical insurance cards and a picture ID so that your insurance company can be billed for charges incurred at your clinic visit.
- **NEW PATIENT:** Be advised to plan at least 1 hour and 30 mts for your first initial visit.
- **MEDICATION REFILL:** In order to obtain refills on your medications prescribed by our pulmonologists, you must be seen at the clinic every 6 months.
- **TEST RESULTS:** Please be advised that the test results are available 24 to 48 hours after the test is performed. If test results are normal, you may not get a telephone call, in this case you may need to call the office to get the results.



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## ACKNOWLEDGEMENT OF PATIENT OFFICE POLICIES

DEAR PATIENT.

We provide courtesy reminder calls to patients for your appointments. If you are unable to keep appointment, you will have to cancel the day before the appointment or you may be charged a no show fee. If the office is closed, you may leave a message with your answering service. If you do not call to reschedule or cancel your appointment, we will consider it a missed appointment.

Please plan on being here for 1 hour for follow up appointments and 1 ½ hours if you a new patient and if you are unable to wait, you should feel free to reschedule.

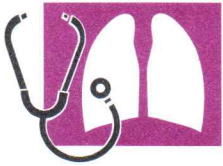
Patients please be aware that there will be fees charged to patient account if you are a no show for your appointments, Pulmonary Function Tests and Sleep Study Tests.

Patients please note that Behavioral issues, Financial Delinquency and 2 or more missed appointments will result in discharge from the practice at the discretion of the provider.

I, \_\_\_\_\_ acknowledge this policy.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



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## PULMONARY QUESTIONNAIRE

DATE: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Chief complaint (*why are you here today?*)  
\_\_\_\_\_

### Respiratory History

#### Cough: Yes or No

If yes, how often; daytime or nighttime \_\_\_\_\_

When was this first noticed? \_\_\_\_\_

What activities make you cough? \_\_\_\_\_

What relieves your cough? \_\_\_\_\_

#### Do you produce sputum (mucus) when you cough? Yes or no

If yes, what color is your sputum? \_\_\_\_\_

Have you coughed up blood? Yes no

#### Shortness of Breath: Yes or No

If yes, when was this first noticed? \_\_\_\_\_

What activities make you short of breath? \_\_\_\_\_

What activities have you given up due to this? \_\_\_\_\_

What relieves your shortness of breath? \_\_\_\_\_

#### Wheezing: Yes or No

If yes, when was this first noticed? \_\_\_\_\_

What activities make you wheeze? \_\_\_\_\_

What relieves your wheezing? \_\_\_\_\_

### System Review: In the last month, have you had:

#### General

Loss of energy

Fever/Chills

Night Sweats

Yes No


#### Skin

Rashes

Change in skin color

Unhealed sores


#### Blood

Unusual bleeding

Easy bruising

Anemia

Enlarges glands


#### Endocrine

Heat/cold intolerance

--	--

#### Cardiac

Heart problems

Chest pain

Heart murmurs

Heart attacks

Fainting

Yes No


#### Gastrointestinal

Abdominal pain

Heartburn

Nausea/vomiting

Diarrhea

Constipation

Blood in stool


#### Urinary

Burning in urine

Blood in urine


Increased hunger

--	--

Trouble in start/stop

--	--

**Eyes/ears/mouth**

Vision trouble  
Double vision  
Eye pain  
Hearing trouble  
Ringing in ears  
Dizziness  
Dental problems  
Difficulty swallowing  
Mouth sores  
Hoarseness


**Muscle/skeleton**

Joint pain  
Morning stiffness  
Back problems  
  
Neurologic  
Blackouts  
Seizures  
Frequent headaches  
Muscle weakness  
Trouble talking  
Balance problems  
Memory changes


**Lungs/nose**

Nose bleeds  
Cough  
Runny nose  
Shortness of breath  
Wheezing  
Cold


**Emotion**

Mood swings  
Crying spells  
Depression  
Psychiatric treatment


**1.Lung Condition**

1. Please list if have any lung related diseases? \_\_\_\_\_

2. Past Medical history: \_\_\_\_\_

Please list your medications: \_\_\_\_\_

Please list your allergies and their reactions: \_\_\_\_\_

**Past Surgical History**

Please list, be complete about *date, and type of surgery* \_\_\_\_\_

**Social History:**

1. Recently traveled overseas? Yes or No. If yes, where \_\_\_\_\_

2. Occupation history \_\_\_\_\_

3. Any Pets? Please list: \_\_\_\_\_

**Alcohol, Drug and Tobacco History**

Cigarettes / Cigar / Pipe (*circle*): Amount per day \_\_\_\_\_ # of years \_\_\_\_\_

Smokeless (chew): Amount \_\_\_\_\_ # of years \_\_\_\_\_

Have you quit? \_\_\_\_\_ # of years/months quit \_\_\_\_\_

How would you describe your use of alcohol? \_\_\_\_\_

Use of recreational intravenous drugs: No Yes

**Vaccine History:**

Have you had a TB (*tuberculosis*) skin test? Yes No

Date of test \_\_\_\_\_ was it positive (reactive)? Yes No

Have you had an *influenza (flu)* vaccine? Yes No If yes, date \_\_\_\_\_

Have you ever had a pneumonia vaccine? Yes No If yes, date \_\_\_\_\_

**Family History: For any lung diseases & sleep disorders please list**

\_\_\_\_\_