Lung, Allergy & Sleep
MEDICINE CENTER

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)

Lung, Allergy & Sleep
MEDICINE CENTER

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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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	Yes	No
Loss of energy	◯	◯
Fever/Chills	◯	◯
Night Sweats	◯	◯
Skin		
Rashes	◯	◯
Change in skin color	◯	◯
Unhealed sores	◯	◯
Blood		
Unusual bleeding	◯	◯
Easy bruising	◯	◯
Anemia	◯	◯
Enlarges glands	◯	◯
Endocrine		
Heat/cold intolerance	◯	◯

Cardiac	Yes	No
Heart problems	◯	◯
Chest pain	◯	◯
Heart murmurs	◯	◯
Heart attacks	◯	◯
Fainting	◯	◯
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	○	○

Lungs/nose

Nose bleeds	○	○
Cough	○	○
Runny nose	○	○
Shortness of breath	○	○
Wheezing	○	○
Cold	○	○

Muscle/skeleton

Joint pain	○	○
Morning stiffness	○	○
Back problems	○	○

Neurologic

Blackouts	○	○
Seizures	○	○
Frequent headaches	○	○
Muscle weakness	○	○
Trouble talking	○	○
Balance problems	○	○
Memory changes	○	○

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

_____