# PATIENT REGISTRATION FORM

MR#: _____ (office use only)  Initial Date: _____/_____/_____

☐ Revised- see addendum.

## Patient Information

Patient's Name: _____ Preferred Name: _____
Last First MI

Social Security #:_____-____-_____ Date of Birth: ____/____/_____ Sex: ☐ Male ☐ Female

Address: _____
Street City State Zip

Home Phone #: (____)_____ Cell #: (____)_____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name: _____ Spouse's Date of Birth _____/_____/_____
If applicable.

## Employment

Employer: _____ ☐ Full Time ☐ Part Time ☐ Retired
☐ Student ☐ None

Occupation: _____

Business Address: _____ Phone #: (____)_____
Street City State Zip

## Physician Information

Referring Physician: _____ Phone #: (____)_____

Primary Care Physician: _____ Phone #: (____)_____

Preferred Pharmacy: _____ Phone # or Location: _____

Patient's Name: _____ Date of Birth: _____/_____/_____

## Responsible Billing Party

Please complete if the responsible billing party is different from the patient listed above.

Name: _____ Date of Birth: _____/_____/_____
Last First MI

Address: _____
Street City State Zip

Social Security #: _____-____-_____ Phone #: (_____)_____ Sex: ☐ Male ☐ Female

Relationship to patient: ☐ Spouse ☐ Partner ☐ Durable Power of Attorney ☐ Other: _____
Please specify.

## Primary Insurance Information

☐ No, I do not have medical insurance.

Insurance Name: _____ Employer: _____

Policy Holder Name: _____ Date of Birth: ____/____/____
Last First MI

Social Security #:_____-____-_____ Member ID: _____ Group #: _____

## Secondary Insurance Policy (if any)

Insurance Name: _____ Employer: _____

Policy Holder Name: _____ Date of Birth: ____/____/____
Last First MI

Social Security #:_____-____-_____ Member ID: _____ Group #: _____

## Emergency Contact

Name: _____ Telephone #: (_____)_____

Relationship to patient: _____

***Pharmacy:* _____**

# PATIENT/FAMILY MEDICAL HISTORY FORM

Date: ____ /_____ /_____

Patient's Name: _____ Date of Birth: _____/_____/_____ (1)

## History of Present Illness

•Reason for visit today (Chief Complaint):

_____

• When did your symptom(s) first start:

_____

• What makes your symptom(s) better:

_____

• What makes them worse:

_____

## Personal Medical History

**CHRONIC MEDICAL CONDITIONS**
(List any present and past medical illnesses)

1. _____
2. _____
3. _____
4. _____
5. _____

**PREVIOUS SURGERY**
(Lung surgery, Heart surgery, others..)

1._____
2._____
3._____
4._____
5._____

**ALLERGIES**

List any allergies to medications and specify what kind of reaction you've experienced from taking that medication.

| **Medication** | **Reaction** |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |
| 4._____ | _____ |

Patient's Name: _____Date of Birth: _____/_____/_____ (2)

**REVIEW OF SYSTEMS:** Please check (√) if you are experiencing any of these symptoms.

| System | Symptoms |
|---|---|
| General | ___Fever ___Sweats/chills ___Weakness ___Weight change ___Fatigue ___Irritability |
| Skin | ___Color changes ___Skin eruptions ___Itching ___Scaling ___Easy bruising |
| Eyes | ___Redness ___Excessive tearing ___Discharge ___Sensitivity to light<br>___Visual changes |
| Ears | ___Pain ___Deafness ___Ringing in ears ___Vertigo ___Itching ___Discharge |
| Nose | ___Frequent colds ___Sinus infections ___Frequent nosebleeds ___Snoring |
| Mouth/throat | ___Dental problems ___Jaw pain or clicking ___Postnasal drainage ___Dry mouth<br>___Sore throat ___Hoarseness ___Frequent throat clearing |
| Respiratory | ___Persistent cough ___Sputum/phlegm ___Wheezing ___Coughing up blood<br>___Pain on breathing ___Shortness of breath ___Difficulty breathing while lying flat |
| Cardiovascular | ___Chest discomfort ___Swelling of ankles ___Palpitations ___Lightheadedness ___Blood clots<br>___ fainting |
| Gastrointestinal | ___Heart burn ___Abdominal pain ___Constipation ___Bloody or black stools ___Jaundice<br>___Difficulty swallowing ___Nausea/vomiting/diarrhea |
| Genitourinary | ___Difficulty urinating ___Painful urination ___ Frequent urination<br>___ Sexual problems ___Kidney stones<br>WOMEN: date of last menstrual period_____ |
| Endocrine | ___Thyroid disorder ___Goiter ___Feel hot or cold when others are not affected |
| Neurologic | ___Frequent headaches ___Dizziness ___Numbness ___ Muscle weakness ___Forgetfulness |
| Musculoskeletal | ___Limited movement of joints ___Swelling of joints ___Painful Joints<br>___Back or neck pain |
| Psychiatric | ___ Anxiety ___ Depression ___ Hallucinations |
| Sleep | ___ Snoring ___ I have been told that I quit breathing ___ Choking/ gasping for air at night<br>___ Restless legs ____ Excessive Sleepiness ____ Nightmares |

**Medications:**

List all your current medications and dosages or provide a list (□ See attached list):

| Medication | Dose | Medication | Dose |
|---|---|---|---|
| 1. | | 8. | |
| 2. | | 9. | |
| 3. | | 10 | |
| 4. | | 11. | |
| 5. | | 12. | |
| 6. | | 13. | |
| 7. | | 14. | |

**PREVENTATIVE CARE**

Have you received a flu shot this year? ☐Yes ☐No

Have you received a pneumonia (Pneumovax) vaccine? ☐Yes ☐No Year received: _____

TB Skin Test? ☐Yes ☐No Results? ☐Pos ☐Neg Chest X-ray done? ☐Yes or ☐No

Do you have an Advanced Directive? ☐Yes or ☐No

*If yes, please allow our office to keep a copy in your records.*

**SOCIAL HISTORY**

Are you working now? ☐Yes ☐No What is (or was) your occupation? _____

Have you been exposed to asbestos, dust or strong fumes at your work? ☐Yes ☐No
If yes, please describe: _____

Do you keep animals at home? ☐Yes ☐No If so, please describe: _____

Have you ever smoked cigarettes? ☐Yes ☐No
If yes: Do you smoke now? ☐Yes ☐No
If so, at what age did you start smoking? _____
At what age did you stop smoking? _____
How many packs a day do/did you smoke? _____

Do you drink caffeine? ☐Yes ☐No
If yes: How often and what kind? _____

Do you consume alcoholic beverages? ☐Yes ☐No
If yes: How often and what kind? _____
Do you consider yourself an alcoholic? ☐Yes ☐No

Do you use recreational/illicit drugs? ☐No, never ☐Yes, in the past ☐Yes, currently
If yes, Please describe _____

**FAMILY MEDICAL HISTORY**

| Disease | Relative | Other Diseases (list) | Relative |
|---|---|---|---|
| Asthma | | Diabetes | |
| Emphysema or COPD | | Cancer of: | |
| Lung cancer | | Pulmonary hypertension | |
| Heart disease | | Other: | |
| Blood clotting disorder | | Other: | |
| High blood pressure | | Other: | |
| High cholesterol | | | |

**Form reviewed and information verified by Dr _____ Sign/date_____**

# PATIENT RECORD OF DISCLOSURES

Date: ____ /_____ /_____

Patient's Name: _____ Date of Birth: _____/_____/_____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

☐Home Telephone: _____
- ☐OK to leave message with detailed information
- ☐Leave message with call-back number only

☐Cell Telephone: _____
- ☐OK to leave message with detailed information
- ☐Leave message with call-back number only

☐Work Telephone: _____
- ☐OK to leave message with detailed information
- ☐Leave message with call-back number only

☐Other: _____
_____

## Release of Information

I hereby authorize Texas Pulmonary and Sleep Clinic, P.A. to release my information to any medical provider such as physician, medical equipment company, or hospital- as well as any insurance company and/or responsible billing party. This information may include diagnosis, records of any treatment, or any examinations rendered.

In addition to the above release, I authorize Texas Pulmonary and Sleep Clinic, P.A. to release any information to:

**Please print name(s)**

☐ Spouse/Partner: _____

☐ Parent: _____

☐ Other: _____

☐ None.

_____ _____
Patient Signature Date

Date: ____ /_____ /_____

Patient's Name: _____ Date of Birth: _____/_____/_____

## Assignment of Benefits

I hereby assign toTexas Pulmonary and Sleep Clinic, P.A. any insurance or other third-party benefits available for health care services provided to me. I authorize direct remittance of payment of all insurance benefits to Texas Pulmonary and Sleep Clinic, P.A. for all covered medical services and supplies provided to me during all courses of treatment and care provided by the Texas Pulmonary and Sleep Clinic, P.A and/or its affiliated entities. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by Texas Pulmonary and Sleep Clinic, P.A. I understand that this assignment of benefits does not relieve my ultimate responsibility for all charges not covered and paid by insurance.

## Consent to Treat

I voluntarily consent and authorize Texas Pulmonary and Sleep Clinic, P.A. and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf.

By signing below, I agree to the terms of this document which I have read and had the opportunity to ask questions about and I acknowledge that I have the opportunity to request and receive a copy of this office's Notice of Privacy Practices and Financial Policy which explains how my medical and billing information will be used and disclosed.

_____ Date_____
(Patient or Patient's Representative)

**For Patient Representatives:**
My relationship to the patient is _____ and I have signed this consent on the patient's behalf.

_____ Date_____
(Witness)