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.____

PAST HOSPITALIZATIONS
Hospitalizations (continue on back of page if more space is needed).

Hospital & City	Reason	Physician	Year
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 ___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 ___Sore throat ___Hoarseness ___Frequent throat clearing
Respiratory	___Persistent cough ___Sputum/phlegm ___Wheezing ___Coughing up blood ___Pain on breathing ___Shortness of breath ___Difficulty breathing while lying flat
Cardiovascular	___Chest discomfort ___Swelling of ankles ___Palpitations ___Lightheadedness ___Blood clots ___ fainting
Gastrointestinal	___Heart burn ___Abdominal pain ___Constipation ___Bloody or black stools ___Jaundice ___Difficulty swallowing ___Nausea/vomiting/diarrhea
Genitourinary	___Difficulty urinating ___Painful urination ___ Frequent urination ___ Sexual problems ___Kidney stones 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 ___Back or neck pain
Psychiatric	___ Anxiety ___ Depression ___ Hallucinations
Sleep	___ Snoring ___ I have been told that I quit breathing ___ Choking/ gasping for air at night ___ 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.	

Patient's Name: ____ Date of Birth:_____/______/______ (3)

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 Williamson County Pulmonary and Sleep Associates 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 Williamson County Pulmonary and Sleep Associates 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 to Williamson County Pulmonary & Sleep Associates 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 Williamson County Pulmonary & Sleep Associates for all covered medical services and supplies provided to me during all courses of treatment and care provided by the Williamson County Pulmonary & Sleep Associates 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 Williamson County Pulmonary & Sleep Associates. 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 Williamson County Pulmonary & Sleep Associates 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)