PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH : _____ / _____ / _____ **SEX :** ☐MALE ☐FEMALE ☐OTHER **SSN :** XXX-XX-_____

PATIENT ADDRESS : _____ **CITY :** _____ **STATE :** _____ **ZIP :** _____

☐ **HOME PHONE :** _____ ☐ **WORK PHONE :** _____

☐ **CELL PHONE :** _____ ☐ **EMAIL :** _____

(Please check the box to indicate your preferred means of communication)

EMPLOYER : _____ **MARITAL STATUS :** _____

RACE : ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ASIAN
☐ HAWAIIAN/PACIFIC ISLANDER ☐ OTHER ☐ UNKNOWN ☐ DECLINED

ETHNICITY : ☐ DECLINED ☐HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐UNKNOWN

LANGUAGE : _____ ☐ **INTERPRETER NEEDED :** _____

SPOUSE'S NAME : _____ **SPOUSE'S DATE OF BIRTH :** _____

EMERGENCY CONTACT : _____ **RELATIONSHIP TO PATIENT :** _____

HOME PHONE : _____ **OTHER PHONE :** _____

PRIMARY CARE PHYSICIAN : _____ **REFERRING PHYSICIAN :** _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME : _____

POLICY HOLDER : _____ **EFFECTIVE DATE :** _____

INSURANCE ID # : _____ **GROUP # :** _____ **PLAN # :** _____

SECONDARY INSURANCE INFORMATION PLAN NAME : _____

POLICY HOLDER : _____ **EFFECTIVE DATE :** _____

INSURANCE ID # : _____ **GROUP # :** _____ **PLAN # :** _____

OTHER INSURANCE INFORMATION PLAN NAME : _____

POLICY HOLDER : _____ **EFFECTIVE DATE :** _____

INSURANCE ID # : _____ **GROUP # :** _____ **PLAN # :** _____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to : **PULMONARY MEDICINE OF DAYTON, INC.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED : _____ DATE : _____

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MEDICAL HISTORY

Name : _____ DOB : _____ Appt Date : _____

Home # : _____ Work # : _____

Referring Physician : _____ Phone : _____
Family Physician : _____ Phone : _____
Cardiologist : _____ Phone : _____
Other Physicians : _____ Phone : _____
Pharmacy : _____ Phone : _____

Why are you seeing the lung doctor (please describe your symptoms) :

_____
_____
_____
_____
_____
Abnormal Chest X-Ray / CT Scan : _____

Current Problems :

Cough _____ How long ? _____
Clear / Green / Yellow (thick / thin / sticky) _____
Coughing up blood _____ Amount (tsp / TBS / Streaks) _____
Shortness of breath (with or without activity) _____
Chest heaviness / pressure / tightness _____
Do you snore (heavy / light) _____
Wheezing (all the time / with activity) _____
Weight Loss (how much / over how long _____
Headaches _____ Fevers _____
Nasal Drainage (clear / green / yellow) _____
Hoarseness in voice _____
Trouble swallowing or choking when eating or drinking _____
Other _____

Have you had the following done? (If yes please mark when and where each was performed)

Breathing Test : _____ Chest X-Ray : _____
CT Scan : _____ Cardiac Stress Test : _____
Heart Catheterization : _____ 2-D Echocardiogram : _____
Pneumonia Vaccine : _____ Flu Vaccine : _____
Tuberculosis Exposure : _____ Last Skin Test (positive / negative) : _____

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MEDICAL HISTORY & FAMILY HISTORY

Name : _____ DOB : _____ Appt Date : _____

Past Medical Problems :

High Blood Pressure Pneumonia COPD/Emphysema Heart Disease

Asthma Diabetes Cancer (when/where) _____

Other _____

Surgeries :

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalizations :

_____ _____

_____ _____

_____ _____

_____ _____

Family History : Any health problems?

Father (Living / Deceased) : _____

Mother (Living / Deceased) : _____

Brothers / Sisters (Living / Deceased) : _____

Children (Living / Deceased) : _____

Other relevant: _____

Habits : Do you do any of the following?

Smoke Cigarettes / Cigars, How many/day _____ How many years _____ Quit When _____

Chew Tobacco _____ Use any other Drugs _____

Alcohol, Type _____ How much per day/week _____

Occupation / Retired / Disabled : _____

Occupational Exposure : Asbestos / Chemicals / Fumes / Dust / Fibers / Metals / Radiation

Coal Miner / Welder / Factory / Farmer / Grinder / Other : _____

Pets (Inside / Outside) / Any Birds : _____

Blood Transfusion (when/why) : _____

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Name : _____ DOB : _____ Appt Date : _____

Medication Allergies (Include Symptoms) :

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications (Include Name, Strength, Dose) :

_____

_____

_____

_____

_____

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_____

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_____

CURRENT CONDITIONS

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Name: Date of Birth: / / Date:

Please circle any of the following that you have experienced in the past 6 months.

Constitution:	Fever	Fatigue	Chills	Night Sweats	Weight Loss	Weight Gain
Cardiovascular:	Chest Pain	Palpitations	Swelling (edema)	Murmurs		
Eyes:	Blurred Vision	Loss of Vision	Double Vision	Glaucoma	Watery Eyes	
Ears, Nose, and Throat	Hearing Loss or Pain	Ringing in ears	Nasal Obstruction	Hoarseness or Sore Throat	Bleeding Gums	Dentures
Allergy/Immunology:	Runny Nose	Sneezing	Allergic reactions	Bloody Nose	Hives	Localized Rash
Hematology/Lymph:	Easy Bruising	Bleeding Tendency	Enlarged Lymph Nodes			
Neurology:	Headaches	Seizures	Coordination Problems	Dizziness		
Skin:	Rash	Itching	Dry Skin	Unusual Moles	Breast Lumps	Skin Sores
Musculoskeletal:	Joint Pain	Joint Swelling	Weakness	Back Pain		
Psychiatric:	Feeling Anxious	Feeling Depressed	Feeling Sad	Thinking of Suicide		
Gastrointestinal:	Heartburn	Nausea Vomiting	Diarrhea/ Constipation	Abdominal Pain	Trouble Swallowing	Changes in Stool
Endocrine:	Excessive Thirst	Excessive Urination	Heat Tolerance	Cold Tolerance		
Genitourinary:	Frequent Urination	Loss of Bladder control	Difficult Urination	Painful urination	Changes in Urine color	

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The staff of Pulmonary Medicine of Dayton, Inc. will not directly use or allow the use of Pulmonary Medicine of Dayton data for any purpose other than that directly associated with any official assigned duties. We understand that all patient's information including financial data will be held strictly confidential. Official HIPAA manual is available for your review.

You have my permission to discuss my medical record information and account with the following individuals:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have received Pulmonary Medicine of Dayton, Inc.'s Notice of Privacy Practices.

Name (Please Print): _____

Signature: _____

Witness: _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name-_____ **Date of Birth-**_____/_____/_____

Telephone #-(_____**)**_____-_____ **Last 4 digits of SSN-**_____

I hereby authorize _____ *to release, use, and disclose health information about me as described below to the following individuals or entities:*

Send To:

_____
_____
_____

Send To:

_____
_____
_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

RELEASE CONTENT

Dates of Service Requested: _____

[ ] COMPLETE MEDICAL RECORD
[ ] PROGRESS NOTES
[ ] HISTORY & PHYSICAL
[ ] LAB/PATHOLOGY REPORTS
[ ] EKG REPORTS
[ ] PFT REPORTS
[ ] DICTATED LETTERS
[ ] ITEMIZED BILL
[ ] RADIOLOGY REPORTS
[ ] OTHER (PLEASE SPECIFY): _____

REASON FOR DISCLOSURE

My health information is being released or disclosed for the following reason(s) (check all that apply)

[ ] PERSONAL
[ ] LEGAL INVESTIGATION OR ACTION
[ ] INSURANCE ELIGIBILITY OR BENEFITS
[ ] CHANGING PHYSICIANS
[ ] OTHER (PLEASE SPECIFY): _____

CONSENT

I understand that I may revoke authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*