

Sussex Pulmonary & Endocrine Consultants, PA

PATIENT INFORMATION

Date: _____

Primary care Physician: _____

Last Name: _____

Referring Physician: _____

First Name: _____

DOB: _____

Address: _____

Sex: M F Transgender Other: _____

City/State/ ZIP: _____

Marital Status: Married Divorced Partnered
Single Widowed Legally Separated Other _____

Home Phone: _____

SSN: _____

Cell No: _____

Employment Status: _____

Work Phone: _____

Employer Name: _____

AUTOMATED TELEPHONIC COMMUNICATIONS

May we send automatic tel. reminders/texts for appointments, general lab. or prescription confirmation? YES NO

If yes, preferred contact No: Home Cell Work

FINANCIAL RESPONSIBLE PARTY

EMERGENCY CONTACT

SELF

Relation to patient: _____

Name: _____

Name: _____

Address: _____

Address: _____

City/ State/ ZIP: _____

City/ State/ ZIP: _____

Home Phone: _____

Home Phone: _____

Cell No: _____

Cell No: _____

INSURANCE INFORMATION

Primary Insurance

Secondary Insurance

Subscriber Dependent

Subscriber Dependent

Subscriber No: _____

Subscriber No: _____

Group No: _____

Group No: _____

If dependent, Insured Name: _____

If dependent, Insured Name: _____

SSN: _____

SSN: _____

DOB: _____

DOB: _____

ADDITIONAL INFORMATION

PLEASE NOTE IF A PO BOX ADDRESS WAS PROVIDED FOR GENERAL MAILING, A PHYSICAL ADDRESS IS COMPULSORY FOR ACCEPTING CERTAIN MAIL SUCH AS CERTIFIED OR MEDICATION RECALL LETTERS

Address: _____

City/ State/ ZIP: _____

RACE: American Indian/Alaskan native Asian Native American African American White
Hispanic Another race Other Pacific Islander Declined to specify

Ethnicity: Hispanic or Latin Not Hispanic or Latin Declined to specify

Sussex Pulmonary & Endocrine Consultants, PA

Language: English Spanish Indian Russian Other: _____

CONFIDENTIAL CONTACT INFORMATION

Please list all those you give permission for us to discuss your medical condition, appointments, and billing information with.

Name: _____ Relation: _____ Phone No: _____

Name: _____ Relation: _____ Phone No: _____

PHARMACY INFORMATION

Please check off the preferred pharmacy

Local Pharmacy Name: _____ Location: _____

Mail Order Pharmacy name: _____

CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

: I authorize Sussex Pulmonary and Endocrine Consultants, PA to view the external prescription history via the Rx Hub service for the patient listed below. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

PRIVACY PRACTICE

: I have read the privacy practice and give my consent to your use and disclosure of my health information.

CONSENT FOR CARE AND TREATMENT

: I do hereby agree and give my consent for Sussex Pulmonary & Endocrine Consultants, PA to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition.

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

: I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Sussex Pulmonary & Endocrine Consultants, PA. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

: We bill your insurance carrier solely as a courtesy to you. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract, except where we are contracted as preferred provider.

: It is your responsibility to know your insurance policy and initiate a referral when necessary. **IF YOU DO NOT HAVE YOUR REFERRAL, YOUR VISIT MAY BE RESCHEDULED OR YOU MAY BE FINANCIALLY RESPONSIBLE FOR THE SERVICES PROVIDED.**

: All patients who do not have medical insurance and patients without valid insurance card are considered self-pay. All SELF-PAY PATIENTS are responsible for payment at the time of the visit.

: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. We accept cash, checks or credit cards.

CANCELLATION

: Please give at-least 24 hours' notice prior to canceling a scheduled appointment. There will be a \$ 25 fees for appointments cancelled within 24 hours or missed. These charges will be your responsibility, billed directly to you and payable prior to the

Sussex Pulmonary & Endocrine Consultants, PA

next appointment. Failure to pay may result in dismissal from the practice. If you miss three or more cumulative visits, you may be dismissed from the practice. Please help us to serve you better by keeping your regular scheduled appointments.

UNPAID BALANCE

: **Balances older than 60 days will be subject to a LATE FEE OF \$25.** Balances not paid within 90 days will be considered past-due and sent to collection agency. In addition, you will be responsible for all costs of collecting monies owed, including, collection agency fees court costs and attorney fees.

: Any patient with a Financial Past Due Account may be denied a future appointment until balance is paid or a payment arrangement is made. We realize that temporary financial problems may affect timely payment of your account. If such a problem arises, we encourage you to contact us immediately to set up a payment plan.

I have read and understand the above information.

Patient / Legal Guardian Signature

Date

PORTAL CONSENT FORM

Sussex Pulmonary and Endocrine Consultants, PA offers secure viewing and communication through its EMR vendor's (eClinicalworks) secure servers as a service to patients who wish to view parts of their records and communicate with our staff and physicians.

Secure messaging can be a valuable communications tool but has certain risks. To manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Sussex Pulmonary and Endocrine Consultants, PA or any of their staff liable for network infractions beyond their control.

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect, and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures, as well as any other instructions that my physician may impose to communicate with patients via online communications. All my questions have been answered and I understand and concur with the information provided in the answers.

Confidential email, please print clearly: _____

Patient / Legal Guardian Signature

Date

SUSSEX PEC Representative Signature

Date

New Patient Medical History Form (Endocrine)
Sussex Pulmonary & Endocrine Consultants, PA

Patient Name: _____ Age: _____ Date of Birth: _____

Reason for Visit: _____ Today's date: _____

Primary Care Provider: _____ Referring Provider: _____

Any other provider that you see on a regular basis: _____

Please check if you have any of the following problems:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart attack/MI | <input type="checkbox"/> Previous stent/Bypass | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> HIV Disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Dementia/Impaired memory | |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> History of cancer: When and where _____ | | | |

Please list all surgeries and procedures:

YEAR	SURGERY	YEAR	SURGERY

Personal & Social History:

Marital Status: Single Married Divorced Separated Widowed partnered

Highest Education Level: Grade ____ High School Some College College Graduate School

Occupation: Employed, where _____ Retired Disabled Unemployed

Alcohol Use: Never Rarely Social Use Daily use Former user; Quit _____

Recreational Drug Use: Never Former user, Quit _____ Current User.

What drugs have you used or currently use: Cocaine Heroine/Narcotics Others: _____

Do you use or have used Marijuana including Medical Marijuana: YES NO?

Smoking History:

Current Smoker: How long have you been smoking? _____.

Average Tobacco use: < ½ pk/day ½ to 1 pk/day 1 to 2 pks/day > 2 pks/day

Former Smoker: When did you quit? _____. How Many years did you smoke? _____

Average Tobacco use: < ½ pk/day ½ to 1 pk/day 1 to 2 pks/day > 2 pks/day

Never Smoker

Have you ever chewed tobacco? YES NO

Family History:

	AGE	ALIVE/DECEASED	HEALTH PROBLEMS
Father			
Mother			
Brother			
Sister			
Children			

Please list your allergies/adverse reaction to medications:

NAME	REACTION	NAME	REACTION

Medication History:

IF YOU HAVE A LIST OF YOUR CURRENT MEDICATIONS PLEASE GIVE TO THE MEDICAL ASSISTANT. IF NOT PLEASE FILL BELOW. PLEASE INCLUDE PRESCRIPTION/OVER THE COUNTER MEDS/VITAMINS/SUPPLEMENTS

Name	Dose	Frequency	Name	Dose	Frequency

If there is anything else that you want to discuss, please list here:

Person providing information: _____

Date: _____