

# 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

Home Phone: \_\_\_\_\_

Single  Widowed  Legally Separated  Other \_\_\_\_\_

Cell No: \_\_\_\_\_

SSN: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employment Status: \_\_\_\_\_

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 Name \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_

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 \$ 50 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 (Pulmonary & Sleep)**

**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:**

- High Blood Pressure       Heart attack/MI       Previous stent/Bypass       High Cholesterol
- Diabetes       Thyroid Problems       Osteoporosis       HIV Disease
- Seizures       Stroke       Dementia/Impaired memory
- Liver Problems       Kidney Disease       Anemia       Arthritis
- Asthma       COPD       Pulmonary Fibrosis       Sleep Apnea
- Anxiety       Depression       Bipolar Disorder       Insomnia
- History of cancer: When and where \_\_\_\_\_
- Have you ever had allergy testing? \_\_\_\_\_
- Sinus Problems or sinus surgery

**Please list all surgeries and procedures:**

YEAR	SURGERY	YEAR	SURGERY

**Check if you use any of the following:**

- Oxygen: If YES Flow Rate \_\_\_\_\_ DME Company: \_\_\_\_\_
- CPAP/BIPAP: If YES DME Company: \_\_\_\_\_
- Nebulizer

**Have you ever been exposed to (as a child or adult) any of the following: (Please check all that apply)?**

- Asbestos     Chemicals, please specify \_\_\_\_\_
- Coal Dust     Silica       Fumes       Birds (Specify) \_\_\_\_\_

**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

**Do you have any Pets?**  NO     YES, what do you have? \_\_\_\_\_

**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
<b>Father</b>			
<b>Mother</b>			
<b>Brother</b>			
<b>Sister</b>			
<b>Children</b>			

**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

PLEASE LIST ANY INHALERS/NEBULIZER MEDICATIONS THAT YOU ARE TAKING

Name	Dose	Frequency

Please list your allergies/adverse reactions to medications:

NAME	REACTION	NAME	REACTION

**New Patient Medical History Form (Pulmonary & Sleep)**

Name: \_\_\_\_\_

**Sussex Pulmonary & Endocrine Consultants, PA**

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This page is intentionally left blank. Please write down anything else that you wish to discuss or any other details of your Past Medical/Surgical/Family/Social History that you want to provide.

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Person providing information: \_\_\_\_\_

Date: \_\_\_\_\_