Sussex Pulmonary & Endocrine Consultants, PA

PATIENT INFORMATION

Date: _____

Primary care Physician: _____

Referring Physician: _____

Last Name: _____

DOB: _____

First Name: _____

Sex: ○ M ○ F ○ Transgender ○ Other: _____

Address: _____

Marital Status: ○ Married ○ Divorced ○ Partnered

City/State/ ZIP: _____

○ 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

☐ **SELF**

Name: _____

Address: _____

City/ State/ ZIP: _____

Home Phone: _____

Cell No: _____

EMERGENCY CONTACT

Relation to patient: _____

Name: _____

Address: _____

City/ State/ ZIP: _____

Home Phone: _____

Cell No: _____

INSURANCE INFORMATION

Primary Insurance

○ Subscriber ○ Dependent

Subscriber No: _____

Group No: _____

If dependent, Insured Name: _____

SSN: _____

DOB: _____

Secondary Insurance

○ Subscriber ○ Dependent

Subscriber No: _____

Group No: _____

If dependent, Insured Name: _____

SSN: _____

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

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
Father			
Mother			
Brother			
Sister			
Children			

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

Please fill out next two pages if you want to be evaluated for any sleep related complaints.

Please consult your spouse/bed partner when answering the following questions. Answer questions as it best describes a typical night or sleep pattern.

What sleep elated complaints do you have? _____

Have you ever had a sleep study before? ☐ NO ☐ YES (Where? _____ When? _____)

On a typical night:

When do you go to bed? _____(time) When do you wake up? _____(time)

How long does it take you to fall asleep? _____ (min/hours)

How many times do you wake up during the night? _____; Typical length of awakening _____

Please circle your choice regarding the indicated problem by using following guideline

1 = Never; 2 = Almost Never; 3 = Sometimes; 4 = Almost Always; 5 = Always

1 2 3 4 5	Snoring
1 2 3 4 5	Awakening others because of snoring.
1 2 3 4 5	Awakening from sleep with choking or gasping.
1 2 3 4 5	Gaps or pauses in breathing during sleep.
1 2 3 4 5	Waking up with a headache in the morning.
1 2 3 4 5	Waking up with dry mouth in the morning.
1 2 3 4 5	Waking up with sour taste in the mouth.
1 2 3 4 5	Feeling un-refreshed after a full night's sleep.
1 2 3 4 5	Falling asleep in boring situations during the day.
1 2 3 4 5	Kicking or leg twitching during night.
1 2 3 4 5	Leg discomfort prior to falling asleep. Describe: _____
1 2 3 4 5	Body rocking during sleep.
1 2 3 4 5	Head banging or rocking during sleep.
1 2 3 4 5	Other body movements during sleep. Describe: _____
1 2 3 4 5	Bedwetting
1 2 3 4 5	Sleepwalking.
1 2 3 4 5	Sleep talking.
1 2 3 4 5	Nightmares or vivid dreams.
1 2 3 4 5	Acting out dreams (shouting, punching in air etc. while sleeping).
1 2 3 4 5	Tooth grinding or clenching.
1 2 3 4 5	Paralysis during sleep or just prior to sleep.
1 2 3 4 5	Sudden loss of muscle control while awake.
1 2 3 4 5	Sudden weakness following an emotional experience.
1 2 3 4 5	Dream during daytime naps.
1 2 3 4 5	Difficulty falling asleep.
1 2 3 4 5	Difficulty staying asleep (waking up in the night).
1 2 3 4 5	Awakening early in the morning even though you do not have to.

THE EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Use the following scale to choose the appropriate number.

0 =Would never dose off 1 = Slight chance of dozing

2 = Moderate chance of dozing 3 = High chance of dozing

SITUATION:	CHANCE:
SITTING & READING	
WATCHING TV	
SITTING IN PUBLIC	
IN A CAR FOR AN HOUR	
LYING DOWN IN THE AFTERNOON	
SITTING AND TALKING TO SOMEONE	
SITTING AFTER LUNCH	
SITTING IN TRAFFIC (PASSENGER)	
TOTAL	

Have you had an accident or a near miss due to falling asleep while driving? ☐ NO ☐ YES.

Please describe the circumstances _____

What is your current weight? _____ lbs. Weight 1 yr. ago? _____lbs. Weight 5 yrs. Ago? _____lbs.

_____

This part of the 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.

_____

_____

_____

_____

Person providing information: _____ **Date:** _____