Sussex Pulmonary & Endocrine Consultants, PA

Patient Information

Date:	SEX: M F	DOB:	
Last Name	First Name:	M.I.	SSN#:
Mailing Add:	City, State, Zip:		
Home No:	Cell No :	Work No:	
Marital Status: Single Married Divorced Widowed Legally separated Partner Unknown		Employer:	
Primary Care Physician:	REFERRING PHYSICIAN:		

Responsible Party Information (Bill To): ☐ SELF ☐ IF NOT SELF PLEASE FILL BELOW

Last Name:	First Name:	M.I.	Resides w/patient: ☐ Y ☐ N
Mailing Add:	City, State, Zip:		
Home No:	Work No:	Other No (cell) :	

Insurance Information (please give card to the receptionist)

Primary Ins:		☐ Subscriber ☐ Dependent	Referral Needed: ☐ Y ☐ N
Name on Card:	SSN	DOB	Group #
Relation to Subscriber: ☐ self ☐ spouse ☐ child ☐ other			Policy #
Secondary Ins:		☐ Subscriber ☐ Dependent	Referral Needed: ☐ Y ☐ N
Name on Card:	Group #	DOB	Group#:
Relation to Subscriber: ☐ self ☐ spouse ☐ child ☐ other			Policy #

Emergency Contact Information

Name:	Relation:	Tel No:

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 RECALL LETTERS

Mailing Add:	City, State, Zip:

Race: Asian Native American Black or African American White Hispanic Other race Other Pacific Islander Refused	
Ethnicity: Hispanic or Latin Not Hispanic or Latin Refused	**Language**: English Other Indian (includes Hindi and other) Spanish Russian

Pharmacy Information: PLEASE CHECK OFF THE PRIMARY PHARMACY USED

☐ LOCAL Pharmacy Name:	☐ MAIL ORDER PHARMACY:

Confidential Contact Information

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

Name:	Relation:
Name:	Relation:

Automated Telephonic Communications

May we send automated telephone reminders for appointments; general lab messages and prescription confirmation? ☐ Y ☐ N	Preferred Phone No: Cell Home Work
Select which reminders are acceptable: ☐ Appointments ☐ Lab Results ☐ Prescription Confirmation ☐ General messages	Preferred time to call: Morning Afternoon Evening

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.

_____ _____

Patient / Legal Guardian Signature Date

PRIVACY PRACTICE

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

_____ _____

Patient / Legal Guardian Signature Date

_____

If Guardian, Relationship to Patient

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.

_____ _____

Patient / legal Guardian Signature Date

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.

_____ _____

Patient / Legal Guardian Signature Date

OFFICE FINANCIAL POLICY STATEMENT

(please read very carefully and initial each one)

_____ 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.

_____ Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Medicare recipients may be asked to sign an ADVANCE BENEFICIARY NOTICE (ABN).

_____ 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. Payment arrangements must be made at the time of the appointment.

_____ 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.

_____ All returned checks will be sent to CHECK VELOCITY , which is a third party check collection services. There may an additional fee imposed by CHECK VELOCITY on you for returned checks.

_____ _____

Patient / Legal Guardian Signature Date

(please read very carefully and initial each one)

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.

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.

PRESCRIPTION REFILLS

_____ We ask that you contact your pharmacy first to request a refill of your medications sent electronically to us. Please allow at-least 48 hours for the refill response.

I have read and understand the above information.

_____ _____

Patient / Legal Guardian Signature Date

_____ _____

SUSSEX PEC Representative Signature Date

PORTAL CONSENT FORM

Purpose of this 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. In order 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.

How the Secure Patient Portal Works?

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology, you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

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.

Only you can make sure these two factors are present. 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.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

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 of my questions have been answered and I understand and concur with the information provided in the answers.

Confidential email, please print clearly: _____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Sussex Pulmonary & Endocrine Consultants, PA

Welcome to our practice. As a new patient, please fill out the information below to the best of your ability.

PATIENT NAME: _____ **BIRTH DATE**: _____ **DATE:**_____

REFERRING PHYSICIAN:_____ PRIMARY CARE: _____

Reason for visit: _____

Do you have any history of? Please circle

Angina /Chest Pain……	Yes	No
MI/Heart Attack……..…	Yes	No
Stents Placed……..….	Yes	No
Bypass Surgery……..….	Yes	No
Congestive heart failure…….	Yes	No
Blood Pressure Problems……...	Yes	No
High Cholesterol……	Yes	No
Stroke…….	Yes	No
Thyroid Problems……..	Yes	No
Diabetes…….	Yes	No
Fractures…….	Yes	No

Location: _____

Asthma……...	Yes	No
COPD/Emphysema…….....	Yes	No
Sleep problems……..	Yes	No
Liver Problems……..	Yes	No
Seizure Disorder……	Yes	No
Arthritis/Joint Pains……...	Yes	No
Kidney Problems……	Yes	No
Alzheimer's/dementia……	Yes	No
History of cancers…….	Yes	No

Location: _____

HIV disease/AIDS…….	Yes	No

Others:

_____

_____

_____

List all the surgeries you have had:

	Date	Type of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

PERSONAL AND SOCIAL HISTORY

Marital status:
☐ single ☐ married ☐ divorced
☐ separated ☐ cohabitating
☐ widowed ☐ partnered

Occupation:
☐ employed at _____
☐ unemployed
☐ retired ☐ disabled

Education:
_____
_____

Do you drink alcohol?
☐ social: freq: _____
☐ daily: qty: _____
☐ rarely: freq: _____
☐ former user ; Quit: _____
☐ none

Caffeine intake:
____ cups per day

Recreational drug use:
☐ current user
☐ former user: Quit: _____
☐ rmarijuana ☐ heroin ☐ cocaine
☐ others: _____

SMOKING HISTORY

Are you a:

☐ current smoker	How long have you been smoking? < 5 yrs 5-10 yrs 10-20 yrs 20-30 yrs 30-50 yrs > 50 yrs	Average smoking: < ½ pk per day ½ to 1 pk per day 1-2 pks per day > 2 pks per day
☐ former smoker	When did you quit smoking? < 6 mon ago 6-12 mons ago 1-5 yrs ago 5-10 yrs ago > 10 yrs ago Quit in : _____	How many yrs did you smoke? < 1 yr 1-5 yrs 5-10 yrs 10-20 yrs 20-30 yrs 30-50 yrs > 50 yrs
☐ Never smoker		☐ Smoking status unknown
☐ Have you ever chewed tobacco?	☐ Yes	☐ No

FAMILY HISTORY

	Age	Medical problems	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:			
Bro Sis	_____	_____	_____
Bro Sis	_____	_____	_____
Bro Sis	_____	_____	_____
Bro Sis	_____	_____	_____

Any Other significant family history: _____

MEDICATION HISTORY

IF YOU HAVE A COMPLETE LIST OF THE MEDICATIONS PLEASE HAND IT TO THE MEDICAL ASSISTANT

OTHERWISE PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING WITH DOSE STRENGTH AND FREQUENCY

MEDICATIONS	DOSE	FREQ	MEDICATIONS	DOSE	FREQ

ALLERGIES/ ADVERSE EFFECTS

NAME	WHAT REACTION?	NAME	WHAT REACTION?
1_____	_____	4_____	_____
2_____	_____	5_____	_____
3_____	_____	6_____	_____

REVIEW OF SYSTEMS

Please check in the appropriate box any symptoms that have been persistent in the last three months:

Yes	No	*General*	Yes	No	*Gastrointestinal*	Yes	No	*Musculoskeletal:*
		Chills			Belly pain			Back pain
		Fatigue			Constipation			Joint pain: _____
		Fever			Diarrhea			Muscle aches
		Loss of appetite			Nausea			Muscle weakness
		Weight change: gain loss			Vomiting			*Dermatological*
		Ears/Nose/Throat			*Endocrine*			Hair loss
		Sinus problem			Breast discharge			Itching
		Ear discharge			Cold intolerance			Nail change
		Hearing loss			Excessive thirst			Rash
		Ringing			Inability to tolerate heat			*Neurological:*
		Sore throat			*Hematological:*			Dizziness
		Eyes			Anemia			Headache
		Blurred vision			Easy bleeding tendency			Memory loss
		Diminished vision			Easy bruising			Seizures
		Discharge			Enlarged lymph nodes			Tingling/numbness
		Double vision			Slow to heal			Tremors
		Cardiovascular			*Urology*			*Psychiatric*
		Chest pain			Blood in urine			Anxiety
		Palpitations			Frequent urination at night			Depression
		Shortness of breath			Pain with urination			Insomnia
		Swelling of ankles			*Male*:			Sleep disturbances
		Respiratory:			Difficulty with erection			*Others*
		Cough			Diminished sexual drive			
		Excessive sputum			*Female*			
		Spitting up blood			Menstrual history:			
		Wheezing			regular			
					irregular			
					postmenopausal			

Would you like to discuss any other issues?

_____

To the best of my knowledge, the questions on this form have been correctly answered.

_____ _____

(Signature of patient, parent or guardian) Date

NEW SLEEP PATIENT HISTORY FORM

What is your current weight? _____ lbs Your weight 1 yr ago? _____ 5 years ago: _____ lbs

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

1. **Do you have any sleep related complaints?**

   _____

2. **Have you ever had a sleep study before? YES NO**

   If yes, where &when was the test performed: _____

   What were the results? _____

3. **During the week I usually:**
   Go to bed at _____ (Time)
   Get up at _____ (Time)
   Sleep at total of_____ (Hours)

   During the weekend I usually:
   Get up at _____ (Time)
   Get up at _____ (Time)
   Sleep a total of (Hours)

4. **It usually takes me _____ minutes to fall asleep**
5. **I usually wake up _____ time(s) during the night**

   Please explain what wakes you up: _____

   Typical length of each awakening: _____

6. **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	

7. 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 as a result of snoring

1 2 3 4 5 Awakening from sleep with choking or gasping

1 2 3 4 5 Snoring more loudly on your back than on your side

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 Falling asleep while reading or watching television

1 2 3 4 5 Falling asleep or nodding off while driving.

Have you had an accident or a near miss due to falling asleep while driving? If yes, please describe the circumstances _____

_____

1 2 3 4 5 Kicking or leg twitching during night

1 2 3 4 5 Leg discomfort prior to or after falling asleep.

If so, please 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.

If so, please 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 day time 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 don't have to

1 2 3 4 5 Tension which increases as bedtime approaches