Pulmonary Associates of North Dallas

Patient Registration Form

Name: ______________________________________DOB ________________________

Address: ____
(Street) (City) (State) (Zip)

Circle the preferred method of contacting you: Home # Cell # Text # Work# Email

Phone: H____________________ W___________________ C____________________

Email Address: ________________________________SSN____________________

Circle the preferred time to contact you regarding appointments: Morning Afternoon Evening

Primary Care Physician______________________________Phone ___________________

Preferred Pharmacy__________________ Address________________________________

Emergency Contact:____
(Name) (Relationship) (Phone Number)

Current Insurance Information is:

Primary____
(Ins. Co. Name) (ID#) (Grp#) (SSN#)

____
(Policy Holder Name) (DOB) (Patient Relation)

____
(Ins. Co. Address) (Ins. Co. Phone)

Secondary____
(Ins. Co. Name) (ID#) (Grp#)

____
(Policy Holder Name) (DOB) (Patient Relation)

____
(Ins. Co. Address) (Ins. Co. Phone)

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

3032 E. Hebron Pkwy.
Suite 101
Carrollton, TX 75010
Tel. 972-865-2880
Fax. 972-306-2564

Joseph V. Surdacki, M.D.
Lezlie M. Miller, P.A.-C

NEW PATIENT QUESTIONAIRE

NAME______________________________**DATE OF BIRTH**______________

NAME & PHONE NUMBER OF REFERRING PHYSICIAN ____

____

NAME & PHONE NUMBER OF PRIMARY CARE PHYSICIAN ____

____

****

WHAT IS THE PROBLEM FOR WHICH YOU ARE SEEING US TODAY? (Please check all that apply)

______**Shortness of breath**

______**Cough**

______**Abnormal Chest X-Ray**

______**Abnormal CT Scan**

______**Pre-operative Evaluation**

______**Sleep Apnea**

______**Other**

Please explain:________________________

____

____

____

____

____

____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING, BOTH REGULAR MEDS AND "AS NEEDED" MEDS. PLEASE INCLUDE INHALERS, CREAMS, DROPS, & SUPPLEMENTS. *PLEASE LIST THE NAME, STRENGTH, DOSE, AND FREQUENCY (HOW OFTEN YOU TAKE IT)—See the examples, and list your meds in a similar fashion*---You can use the back of this page as well if you run out of spaces

	DRUG NAME	STRENGTH	DOSE	FREQUENCY
EXAMPLE	Furosemide	40 mg	1 tablet	Twice a day
EXAMPLE	Symbicort	160/4.5	2 puffs	Twice a day
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

PLEASE LIST ANY *PAST AND CURRENT* MEDICAL PROBLEMS FOR WHICH YOU HAVE RECEIVED TREATMENT (Ex: Diabetes, Cancer, High Blood Pressure, Pneumonia, etc)—*LIST SURGERIES IN NEXT SECTION*

____

____

____

____

PLEASE LIST ANY SURGERY YOU HAVE HAD IN THE PAST AND THE APPROXIMATE YEAR THAT THE SURGERY WAS DONE---Please list them from most recent to most distant.

	YEAR	**SURGICAL PROCEDURE**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PLEASE LIST ANY ALLERGIES TO MEDICATIONS AND THE SPECIFIC REACTION YOU HAD TO THAT DRUG (Rash, trouble breathing, etc.)

	DRUG NAME	**REACTION**
1.		
2.		
3.		
4.		

FAMILY HISTORY

Mother:	**Living_____ Age_____** **General health_____________**	**Deceased_____ Age at death_____** **Cause of death_________________**
Father:	**Living_____ Age_____** **General health_____________**	**Deceased_____ Age at death_____** **Cause of death_________________**

Brothers & Sisters:

LIVING	DECEASED
Age:_____ M/F_____ Health_________	**Age:_____ M/F_____ Cause________**
Age:_____ M/F_____ Health_________	**Age:_____ M/F_____ Cause________**
Age:_____ M/F_____ Health_________	**Age:_____ M/F_____ Cause________**
Age:_____ M/F_____ Health_________	**Age:_____ M/F_____ Cause________**
Age:_____ M/F_____ Health_________	**Age:_____ M/F_____ Cause________**

How many children do you have?____

Do any of your children have significant medical problems? If so, please list:

____

____

If any of your *BLOOD* relatives have any of these conditions, please check and list their relationship to you:

______Asthma ____
______Chronic Bronchitis ____
______Emphysema ____
______Allergies ____
______Diabetes ____
______Heart Disease ____
______High Blood Pressure ____
______Stroke ____
______Cancer ____
______Tuberculosis ____
______Blood Clots ____
______Cystic Fibrosis ____

SOCIAL HISTORY

Marital status:

_____Single _____Married _____Partnered
_____Divorced _____Separated _____Widowed

Smoking Status:

_____Never Smoked _____Former Smoker _____Current Smoker

If you quit smoking, what month and year did you quit? ____________

If you currently smoke or have smoked in the past, how much did you smoke?

_______Average number of packs per day _______Number of years

Alcohol/Drug Use:

Do you drink alcohol? _____None _____Rarely _____Socially
_____Daily (if daily, how many drinks per day? _________)

Do you or have you used recreational/illegal drugs? ___________
If so, what have you used? _________________________________

Occupation:

Are you currently: _____Employed _____Self Employed _____Retired
_____Homemaker _____Student _____Unemployed

Please list all jobs from most recent to most distant:

	YEARS WORKED	JOB DESCRIPTION
1.		
2.		
3.		
4.		
5.		
6.		

Have you been exposed to toxic agents at work (asbestos, radiation, chemicals)?

If so, describe ____

REVIEW OF SYSTEMS

Please note any symptoms or conditions you are experiencing:

General

___Yes___No--Anxiety

___Yes___No--Chills

___Yes___No--Fever

___Yes___No--Night Sweats

___Yes___No--Fatigue

___Yes___No--Weakness

___Yes___No--Loss of Appetite

___Yes___No--Weight Gain

___Yes___No--Weight Loss

Eyes

___Yes___No--Blurred vision

___Yes___No--Diminished vision

___Yes___No--Loss of vision

___Yes___No--Cataracts

___Yes___No--Eye irritation

___Yes___No--Eye pain

Ears

___Yes___No--Decreased hearing

___Yes___No--Loss of hearing

___Yes___No--Ringing in ears

___Yes___No--Discharge from ears

___Yes___No--Ear pain

Nose/Throat

___Yes___No--Sinus problems

___Yes___No--Seasonal allergies

___Yes___No--Year-round allergies

___Yes___No--Sinus pain

___Yes___No--Sinus drainage

___Yes___No--Nasal congestion

___Yes___No--Frequent nosebleeds

___Yes___No--Sore throat

___Yes___No--Trouble swallowing

___Yes___No--Change in voice

Cardiovascular

___Yes___No--Chest pain

___Yes___No--Irregular heart beat

___Yes___No--Chest tightness

___Yes___No--Palpitations

___Yes___No--Murmur

___Yes___No--Leg swelling

___Yes___No--Leg pain with walking

___Yes___No--Clots in the legs

Gastrointestinal

___Yes___No--Nausea

___Yes___No--Vomiting

___Yes___No--Diarrhea

___Yes___No--Constipation

___Yes___No--Changed bowel habits

___Yes___No--Heartburn

___Yes___No--Blood in stool

___Yes___No--Dark tarry stools

___Yes___No--Abdominal pain

Musculoskeletal

___Yes___No--Arthritis

___Yes___No--Joint pain

___Yes___No--Joint stiffness

___Yes___No—Joint swelling

___Yes___No--Muscle aches

___Yes___No--Back pain

___Yes___No--Osteoporosis

___Yes___No--Fracture

___Yes___No--Carpal tunnel

___Yes___No--Sciatica

Neurological

___Yes___No--Headache

___Yes___No--Memory loss

___Yes___No--Seizures

___Yes___No--Gait abnormality

___Yes___No--Dizziness

___Yes___No--Fainting spells

___Yes___No--Tremors

___Yes___No--Tingling

___Yes___No--Numbness

Urological

___Yes___No--Blood in urine

___Yes___No--Kidney stones

___Yes___No--Difficulty urinating

___Yes___No--Frequent urination

___Yes___No--Nocturnal urination

___Yes___No--Urinary infections

___Yes___No--Incontinence

Have you travelled anywhere outside the United States in the last 3 years? If so, where?

____

____

Please list any pets and if they are outdoor or indoor:

____

____

Are you on any special diet? If so, what kind?

____

Do you exercise regularly? If so, describe below:

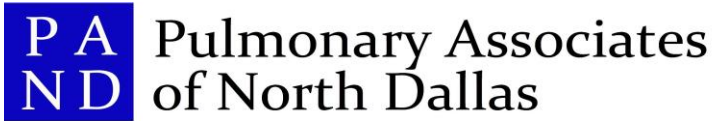
Type:_______________________ Duration:__________min

Frequency:_____________times per week

THE ABOVE INFORMATION WAS FILLED OUT BY:

_____Patient _____Other (please note your relation)_______________

Signature____________________________________Date_____________



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NO SHOW POLICY

Pulmonary Associates of North Dallas is committed to helping you manage and maintain your pulmonary health. When you schedule an appointment, time is reserved exclusively for you to discuss and review your medical concerns. Please utilize the automated reminder system that our office uses to remind you of your appointment two days in advance which gives you the option to confirm or cancel your appointment. We do understand that, on occasions, unforeseen circumstances can arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask that you call our office at least 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to be seen.

The following no-show and/or late cancellation fee will be assessed:

A **$50 charge** will be assessed for "no-showing" or for failing to give 24 hour notice of the need to cancel your appointment.

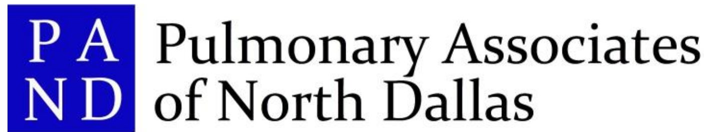
These charges are **not billable** to your insurance and will ultimately be the responsibility of the patient. All no-show charges will need to be paid before your next appointment.

I have read the NO SHOW POLICY and I understand that I will be charged a fee for a late cancellation (less than 24 hours) or a no show for a scheduled appointment.

Patient Signature____

Printed Name____

Date____



Pulmonary Associates of North Dallas Policy

Patient Name:____________________________________ Date of Birth:________________________

BASIC POLICY Pay for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments are due and payable at the time service is provided.
NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. You may be charged for missed appointments.

Please check one: I have paid my insurance deductible for the calendar year_______ [] Yes [] No

MEDICARE/MEDIGAP AUTHORIATION: I request payment of authorized Medicare benefits and, if applicable, Medigap benefits be made on my behalf to Pulmonary Associates of North Dallas for any services furnished me by the listed provider/supplier. I authorize any holder of Medical information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print as Shown on Medicare Card):_______________________________________

Patient's Signature:____

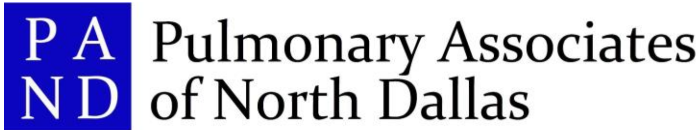
Patient's Medicare No:____________________________ Date:__________________________

ASSIGNMENTS OF INSURANCE BENEFITS Patients with insurance please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Pulmonary Associates of North Dallas. 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 I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:____ **Date**:_________________

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature:____ Date:________________________



Authorization for Use and Disclosure of Protected Health Information

I______________________________, hereby authorize, Pulmonary Associates of North Dallas to use and/or disclose the following protected health information (PHI) to:

Name____
Relationship______________________

Name____
Relationship______________________

□ **I DO NOT** authorize Pulmonary Associates of North Dallas to release my PHI to anyone other than myself. I understand that by doing so it may take longer to get results.

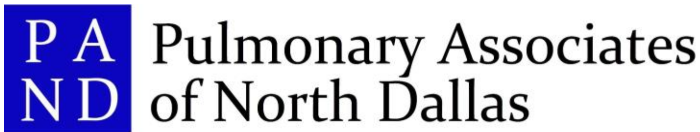
May we leave a voicemail regarding medical information and/or financial responsibility?
□ YES □ NO
Preferred Contact Number: _____________________ □ Cell □ Home □ Work

This PHI is being used or disclosed for the following purposes:
Provide appointment reminders and financial responsibility.
Describe or recommend treatment alternatives
Provide information about health-related benefits and services that may be of interest to the individual.
Soliciting funds to benefit the covered entity

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

_______________________________ ______________
Signature of the Patient or Representative/ Guardian Date

____
Printed Name of Patient or Representative/Guardian



Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME **DATE**

I **understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Pulmonary Associates of North Dallas may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Pulmonary Associates of North Dallas has a detailed document called the ***'Notice of Privacy Practices'.*** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice '* before signing this agreement. If I ask, Pulmonary Associates of North Dallas will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Pulmonary Associates of North Dallas to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Pulmonary Associates of North Dallas has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices,* including any revisions of our *'Notice '* at any time by contacting: Pulmonary Associates of North Dallas ph. 972-865-2880 fax 972-306-2564.

FORM Us

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HIPAA Compliance Program