Pulmonary Associates of Richmond

Name: **Home Phone#:**

Address One: **Work Phone#:**

City: **Cell Phone#:**

State: **Zip:** **Sex:**

Social Security Number: **Date of Birth:**

Referring Doctor: **Employer:**

Primary Care Doctor: **Employment Status:**

Marital Status: **Email address:**

Language:

Emergency Contact: **Race:**

Emergency Home Phone#: **Ethnicity:**

Emergency Work Phone#: **Patient MR#:**

INSURANCE SUBSCRIBER (if different than patient)

Name: **Date of Birth:**

Social Security#:

Relationship: **Employer:**

INSURANCE INFORMATION

Primary Insurance Name: **Secondary Insurance Name:**

*****Please let us know if you have additional insurance**

ADDITIONAL INFORMATION

1. **Do you live in a skilled nursing facility? _____**
2. **How did you hear about our practice? _____**

DISCLOSURE TO FAMILY AND FRIENDS

I authorize Pulmonary Associates of Richmond, Inc. to disclose/discuss my private information relating to my health care services to those individuals listed below as needed. I understand that only information relative to my current treatment will be disclosed.

Name **Relationship**

Signed: Date:

Financial Policies

Thank you for choosing Pulmonary Associates of Richmond, Inc. We are committed to your health and to offering exemplary service. The following is a statement of our Financial Policies. We require all patients, to read and sign this document prior to treatment being rendered.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, CREDIT CARD (VISA, MASTERCARD, AND AMERICAN EXPRESS) AND DEBIT CARDS.

Insurance

We require co-payments be made at the time of service. We will bill your insurance company as a courtesy to you. In order for us to properly file your claims, we must have the most up-to-date information regarding your insurance coverage. For this reason, you may be asked to present your insurance card(s) at each visit. I hereby authorize my insurance benefits to be paid directly to Pulmonary Associates of Richmond, Inc. and acknowledge that I am financially responsible for any unpaid portion of my bill.

Referrals

Some insurances require subscribers to have a referral from a primary care physician prior to being seen by a specialists (such as a Pulmonologist). If a referral is needed, no services will be rendered until the referral has been received or the patient pays for the services at the time they are rendered.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge a fee for a missed appointment. The no show fee for follow up appointments is $50, for new patients it is $150, and for sleep studies it is $250.

Fees for Letters and Forms

Your physician will fill out forms that you may need (e.g., workers compensation forms, FMLA forms, etc). Please be advised that due to the time required to dictate letters/complete forms there will be a fee for this service. Those costs are not covered by the insurance companies. A fee schedule is available upon request.

Returned Checks

In the event that a check is returned for insufficient funds, a $38 returned check fee will be added to your account.

Collection Fees

In the event that your account becomes delinquent, I will be responsible for all cost of collection including administrative charges and attorney's fees of 33.3% plus court costs and interest at the rate of 18% annually.

I have read the above Financial Policies and I understand and agree to them.

_____ _____

Signature of Patient or Responsible Party Date

Written Acknowledgement of Privacy Practices

Our Notice of Privacy Practices Provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our Notices, you may obtain a revised copy.

I have received a copy of the Pulmonary Associates of Richmond, Inc. Notice of Privacy Practices. I understand that I may ask questions if I do not understand any information contained in the Notice.

_____ _____

Signature of Patient or Responsible Party Date

PULMONARY ASSOCIATES OF RICHMOND

Patient History Form

Patient Name:_____

Date:_____

Pharmacy Name: _____ Phone #: _____

Pharmacy Street or Intersection: _____ Pharmacy City:_____

Referred by: _____ PCP: _____

Other physicians you would like us to send a copy of your records to: _____

Reason for today's visit: _____

Please list DATE & REASON for any ER visits or hospitalizations since your last office visit: _____

_____

Medical History (check all that apply)

Condition	Yes	Condition	Yes	Condition	Yes
Abnormal chest x-ray		Emphysema		Osteoporosis	
Acid Reflux		Endocrine Disorder		Oxygen Use	
Allergy testing		Fibromyalgia		Pancreatitis	
Amyotrophic Lateral Sclerosis		Fibrosis		Paralysis	
Anxiety Disorder		Fracture		Parkinson's Disease	
Anemia		Gallstones		Pleural Effusion	
Arthritis		Glaucoma		Pleurisy	
Asthma		Heart Attack		Pneumonia	
Autoimmune Disorder		Heart Disease		Pneumothorax	
Bladder Disease		Heart Failure		Psychological conditions	
Blocked Coronary Arteries		Heart Valve Disorder		Pulmonary Fibrosis	
Blood Clots in legs		Hepatitis		Radiation treatments to the chest	
Blood Clots in lungs		Hernia		Recurrent Infections	
Blood Transfusion		High Blood Pressure		Rheumatic Fever	
Bronchitis		High Cholesterol		Rheumatoid Arthritis	
Cancer		HIV-Positive		Sarcoidosis	
Type:		Hyperthyroidism		Scleroderma	
Cataract		Hypothyroidism		Scoliosis	
Chronic Respiratory Failure		Immune Disorder		Seizures	
Colitis		Jaundice		Sexually Transmitted Disease	
Collapsed lung		Kidney Disease		Single Kidney	
Colon/Intestinal problems		Kidney Stone		Sleep Apnea	
Congestive Heart Failure		Kidney/Hemodialysis		Stroke	
COPD		Kidney/Peritoneal failure Disease		Thyroid Disease	
CPAP use		Lung Scarring		Tuberculosis	
Depression		Lupus		Ulcer disease	
Diabetes		Neurological disorder		Ulcers	
Diverticulitis of Colon		Osteoarthritis		Other:	

Allergies (please list environmental and medications)

Allergy:	Type of Reaction:

Immunization History

	Yes	No	Date received:
Pneumonia vaccine			
Flu vaccine			
Shingles vaccine			

Family History

Condition (check if applicable)	**Yes**	**Who**	**Condition**	**Yes**	**Who**
Amyotrophic Lateral Sclerosis			Heart Disease		
Arthritis			Hypertension		
Asthma			Kidney Disease		
Blood Clots in legs			Lung Disease		
Blood Clot in lungs			Lupus		
Cancer -			Osteoarthritis		
Type:			Rheumatoid Arthritis		
Cardiovascular Disease			Sarcoidosis		
COPD			Scarring on the lungs		
Diabetes			Sleep Apnea		
Emphysema			Stroke		
Family History Unknown			Tuberculosis		
Family History Unknown-Adopted			Scleroderma		
Heart Attack			Other:		

Social History

Marital Status (circle one)	Single	Divorced	Married	Widowed	Partner
Who lives at home with you? _____					
	Occupation		Employer		
Current					
Past					

Exposure History

Tobacco Use	Never	Past	Current	Age Started	Age Stopped	Packs per day
Cigarettes						
Pipe						
Cigar						
Snuff						
Chew						

Alcohol Use	Never	Occasional	Frequency	Past Use
Recreational Drug Use				

Check all that apply:	YES	Home	Work	Other
Tobacco smoke exposure				
Asbestos exposure				
Dust exposure				
Fume exposure				

Traveled outside USA in past 10 years		Where:	
Tuberculosis exposure		Details:	
Positive tuberculosis test		Date:	
Pets in the Home		Type:	
Anything new in home that could cause breathing problems? (carpet, paint, heating system, mold, etc)		What:	

Nebulizer:_____ Oxygen:_____ Supplier:_____

CPAP/BIPAP:_____ Research:_____

Medications and Dosage	**Date**	**Date**	**Date**	**Date**

Past Surgery or Hospitalization History

Date	Reason	Doctor	Hospital

Review of Symptoms (check all that apply currently)

General	Yes	**Throat**	Yes	**Genitourinary**	Yes
Fever		Soreness		Pain	
Night sweats		Hoarseness		Incontinence	
Weight loss		Trouble swallowing		Frequent urination	
Weight gain		**Respiratory**		Up at night	
Skin		Wheezing		Blood in urine	
Rashes		Cough		**Musculoskeletal**	
Cyanosis (blue tint)		Shortness of Breath		Stiffness	
Jaundice (yellow tint)		Daytime sleepiness		Joint swelling	
Eyes		Snoring		Joint pain	
Double vision		Coughing blood		**Neurological**	
Blurring		**Cardiovascular**		Numbness	
Glasses/Contacts		Palpations		Weakness	
Discharge		Chest pain		Headache	
Ears		Swelling of extremities		**Psychiatric**	
Deafness		**Gastrointestinal**		Anxiety	
Ringing in ears		Abdominal pain		Depression	
Pain		Nausea/vomiting		Hallucinations	
Discharge		Diarrhea		**Endocrine**	
Nose		Constipation		Excessive thirst	
Sinusitis		Bleeding		Cold intolerance	
Obstruction		Indigestion		Heat intolerance	
Nose bleeds					
				Blood/Lymphatic	
				Swollen glands	
				Bruising	
				Bleeding	

Do you have an advanced Medical Directive? **Yes** **No**

(Living Will, Health Care Proxy, or Health Care Power of Attorney)

_____ _____

Physician signature Date

Patient's Name: _____

Date:_____

Date of Birth: _____

Chart # _____

SLEEP QUESTIONNAIRE

Thank you for helping us to take better care of you. Please complete the following information:

1. Please describe your sleep problem:			
2. How long ago did this problem begin?			
3. What does your spouse/significant other feel is your sleep problem?			
4. Have you ever been treated for this problem?		□ Yes	□ No
5. Have you ever had sleep testing before?		□ Yes	□ No
6. Are you using Oxygen?		□ Yes	□ No
7. Are you on: (circle one)	CPAP / BiPAP		
8. Do you snore?		□ Yes	□ No
9. Do you stop breathing while asleep?		□ Yes	□ No
10. Do you wake up choking or gasping for air?		□ Yes	□ No
11. When you wake up in the morning, do you have:	Headaches?	□ Yes	□ No
	Dry Mouth?	□ Yes	□ No
	Sore throat?	□ Yes	□ No
	Confusion or Lethargy?	□ Yes	□ No
	Low Mood?	□ Yes	□ No
12. How many times per night do you get up to go to the bathroom? (circle one)		0, 1, 2, 3, 4, 5	
13. Do you feel tired when you wake up?	□ Frequently	□ Sometimes	□ Rarely
14. How restless is your sleep?	□ Extremely	□ Somewhat	□ Not at all
15. Is your sleep disturbed by:	Coughing?	□ Yes	□ No
	Nasal Congestion?	□ Yes	□ No
	Heartburn/reflux?	□ Yes	□ No
	Acting out dreams?	□ Yes	□ No
	Talking in your sleep?	□ Yes	□ No
	Walking in your sleep?	□ Yes	□ No
	Pain?	□ Yes	□ No
16. Do you have a bed partner?		□ Yes	□ No
17. Do you have pets that sleep in your bed?		□ Yes	□ No
18. Are you bothered by movements or snoring of others in your bed or in your room?		□ Yes	□ No
19. Do you leave the television on all night?		□ Yes	□ No
20. Is your bedroom dark and quiet at nights?		□ Yes	□ No
21. Do you eat or read in bed?		□ Yes	□ No
22. Have you been diagnosed with a seizure disorder?		□ Yes	□ No
23. Does your bed partner tell you that you kick or jerk your legs (or your arms) frequently when you are asleep?		□ Yes	□ No
24. When sitting or lying down, do you have uncomfortable or creepy-crawly sensations in your legs (and sometimes in other parts of your body), tied to a strong urge to move? (If NO, skip to # 28)		□ Yes	□ No

Date:_____

25. Do the sensations and urge to move bother you more in the evening and at night rather than during the day?			□ Yes	□ No
26. Do other family members experience these same symptoms?			□ Yes	□ No
27. Do you have involuntary leg jerks when you are awake?			□ Yes	□ No
28. Do you often have trouble falling asleep or staying asleep?			□ Yes	□ No
29. Have you ever experienced sudden body or leg weakness brought on by laughter, surprise, fear, or when hearing or telling a joke? How often does this happen?Travis6316 30.			□ Yes	□ No
31. Have you ever suddenly fallen to the ground without losing consciousness or fainting?			□ Yes	□ No
32. Have you ever experienced seeing or hearing things that were not real just as you were going to sleep or just waking up?			□ Yes	□ No
33. Just as you are waking up or falling asleep, have you ever had the sensation that you cannot move although you are awake and aware of your surroundings?			□ Yes	□ No
34. Do you wake up too early in the morning, unable to return to sleep?			□ Yes	□ No
35. How do you ordinarily awaken?	□ Spontaneously		□ Alarm Clock	□ Other
36. For each of the following, please write in the average number that you drink each day:			<u>Brand</u>	<u>Cups a day</u>
Coffee				
Tea				
Carbonated beverages				
37. What are your usual working hours?	Start:		Stop:	
38. Describe your work schedule, include shift changes:				
39. List your sleeping hours during workdays:	Bedtime:		Get up:	
40. List your sleeping hours during non-workdays:	Bedtime:		Get up:	
41. After getting into bed, how long do you wait before turning out the lights?				
42. How long does it usually take you to fall asleep after turning out the lights?				
43. On average, how many times do you wake up during the night?				
44. On average, how many times do you get out of bed during the night?				
45. If you get up at night, what wakes you up or gets you up?				
46. Do you nap? (If NO, skip to # 51)			□ Yes	□ No
47. How many days per week do you nap?				
48. How many times per day do you nap?				
49. How long are your naps?				
50. Do you find naps refreshing?			□ Yes	□ No
51. Do you have vivid dreams while you nap?			□ Yes	□ No
52. Do you find yourself falling asleep when you don't intend to?			□ Yes	□ No
53. Does daytime sleepiness interfere with:	Daily job performance?		□ Yes	□ No
	School?		□ Yes	□ No
	Relationships/family time?		□ Yes	□ No
	Activities you enjoy?		□ Yes	□ No

Date:_____

54. Do you feel you have more problems concentrating recently?		□ Yes	□ No
55. Have you felt less interested in sex recently?		□ Yes	□ No
56. Do you feel more irritable lately?		□ Yes	□ No
57. Do you ever fall asleep driving?		□ Yes	□ No
58. Have you ever had a car accident or a "near miss" due to falling asleep?		□ Yes	□ No
59. Please check next to any of the following that you experienced as a child or currently experience:	Bed wetting	□ Yes	□ No
	Falling out of bed	□ Yes	□ No
	Head banging	□ Yes	□ No
	Seizures	□ Yes	□ No
	Snoring	□ Yes	□ No
	Rocking yourself to sleep	□ Yes	□ No
	Sleep terrors/nightmares	□ Yes	□ No
	Inability to sleep	□ Yes	□ No
	Sleep walking	□ Yes	□ No
	Asthma	□ Yes	□ No
	Sleep talking	□ Yes	□ No
	Other	□ Yes	□ No
60. Does anyone in your family have a sleep disorder?		□ Yes	□ No
61. If so, who is it and what kind of sleep disorder is it?			
62. Is your father alive?		□ Yes	□ No
63. If not, what did he die of?			
64. Is your mother alive?		□ Yes	□ No
65. If not, what did she die of?			

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = Would Never Doze, 1 = Slight Chance of Dozing, 2 = Moderate Chance of Dozing, 3 = High Chance of Dozing

Situation	**Chance of Dozing**
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place	
As a passenger in a car, for an hour	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch, without alcohol	
In a car, while stopped for a few minutes, in traffic	
TOTAL SCORE	

Date:_____

Please respond to the following statements by circling on number in each row:

	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	A GOOD PART OF THE TIME	MOST OF THE TIME
I feel down hearted, blue and sad	1	2	3	4
Morning is when I feel the best	4	3	2	1
I have crying spells or feel like it	1	2	3	4
I have trouble sleeping through the night	1	2	3	4
I eat as much as I use to	4	3	2	1
I enjoy looking at, talking to and being with attractive women/men	4	3	2	1
I notice that I am losing weight	1	2	3	4
I have trouble with constipation	1	2	3	4
My heart beats faster than usual	1	2	3	4
I get tired for no reason	1	2	3	4
My mind is as clear as it use to be	4	3	2	1
I find it easy to do the things I use to	4	3	2	1
I am restless and can't keep still	1	2	3	4
I feel hopeful about the future	4	3	2	1
I am more irritable than usual	1	2	3	4
I find it easy to make decisions	4	3	2	1
I feel that I am useful and needed	4	3	2	1
My life is pretty full	4	3	2	1
I feel that others would be better off if I were dead	1	2	3	4
I still enjoy the things I used to	4	3	2	1
TOTALS BY COLUMN				
TOTAL SCORE				

Thank you for completing this questionnaire. For more information on sleep, visit us online at www.PARsleep.com.