Welcome, AND thank you for choosing our practice! Included below is information to help you prepare for your visit.

For every appointment with our office, please check in 20 minutes prior to your scheduled appointment time. This will allow us to ensure we have all the necessary information for each visit with your provider.

In an effort to provide you with the best possible care, our office will require:

**First Appointment** –
- Picture ID
- Insurance cards
- Pharmacy Information (Name and Phone number)
- If your insurance requires a copay, please be prepared to pay at the time of your visit.
- Completed New Patient Packet (Attached)
- Medication List (Attached)
- Copies of your most recent chest imaging (Chest X Ray, CT Chest, PET Scan, etc.)
  *Please obtain the disk/film to bring to your appointment*
- Any pertinent Medical records that will assist in your visit
- If you are scheduled for a breathing related concern, please refrain from using a rescue inhaler/nebulizer 2 hours prior to appointment time as we may perform a Spirometry breathing test

**Every Follow Up Appointment** –
- Completed brief questionnaire (Provided upon check-in)
- Copy of current medication list
- If your insurance requires a copay, please be prepared to pay at the time of your visit.
- Copies of your most recent chest imaging (Chest X Ray, CT Chest, PET Scan, etc.)
  *Please obtain the disk/film to bring to your appointment*
- If you are also scheduled for a Spirometry breathing test, please refrain from using a rescue inhaler/nebulizer 2 hours prior to appointment time

If you have been treated for a pulmonary/respiratory condition at Urgent Care, ER or been hospitalized since your last appointment, please notify our office so we may obtain the records for your appointment.

**Full Pulmonary Function Test** –
- Copy of current medication list
- Refrain from using a rescue inhaler/nebulizer 4 hours prior to appointment time
- Refrain from smoking 1-hour prior to appointment

Thank you for the opportunity to be a part of your health care team!

Pulmonary Associates, PA
PULMONARY ASSOCIATES, PA
New Patient Medical History Form

Name: ________________________________  Date of Birth: ____________________________
Date: ____________ Referring Provider: _____________________________ Primary Care Provider: ____________________________

Why are you seeing a pulmonary (lung) provider? ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have you recently been hospitalized: Yes  No  When: _______ month/year  Where: ________________
Have you recently been in Urgent Care: Yes  No  When: _______ month/year  Where: ________________

Have you recently had any of the following:
☐ Chest X Ray  When: ____________ month/year  Where: ____________________________
☐ Chest CT (cat scan)  When: ____________ month/year  Where: ____________________________
☐ Echocardiogram  When: ____________ month/year  Where: ____________________________

Have you had exposure to chemicals: Yes  No  Type: ____________________________________________________________________________
Have you recently traveled outside of the country: Yes  No  Where: _______________________________________________________________________

Have you had Flu Vaccine(s): Yes  No  I do not wish to have vaccines
Please list the last 2: _________ month/year, _________ month/year

Have you had Pneumonia Vaccine(s): Yes  No  I do not wish to have vaccines
Which one and when:  Prevnar 13 _________ date,  Pneumovax _________ date
## REVIEW OF SYMPTOMS

Please check any symptoms you are CURRENTLY experiencing below:

### GENERAL
- □ NONE
- □ Fatigue (easily tired)
- □ Malaise (generally unwell)
- □ Fevers
- □ Chills
- □ Night Sweats
- □ Recent Weight Loss
- □ Recent Weight Gain

### GASTROINTESTINAL
- □ NONE
- □ Abdominal Pain
- □ Constipation
- □ Diarrhea
- □ Heartburn
- □ Loss of Appetite
- □ Nausea
- □ Vomiting

### MUSCULOSKELETAL
- □ NONE
- □ Back Pain
- □ Joint Pain
- □ Joint Swelling
- □ Muscle Weakness

### HEMATOLOGIC/LYMPHATIC
- □ NONE
- □ Easy Bleeding
- □ Easy Bruising
- □ Swollen Lymph nodes/glands

### IMMUNOLOGIC
- □ NONE
- □ Seasonal Allergies
- □ Contact Allergies
- □ Food Allergies
- □ Inhalation Allergies

### RESPIRATORY
- □ NONE
- □ Cough
- □ Shortness of Breath
- □ Coughing up Blood
- □ Pain with Breathing
- □ Wheezing
- □ Known TB Exposure

### PSYCHOLOGICAL
- □ NONE
- □ Anxiety
- □ Depression

### DERMATOLOGIC
- □ NONE
- □ Hives
- □ Rash
- □ Itching
- □ Skin Lesions

### SLEEP
- □ NONE
- □ Insomnia
- □ Wake with Gasping/Choking
- □ Sleepiness During the Daytime
- □ Restless Sleep
- □ Snoring

### CARDIOVASCULAR
- □ NONE
- □ Chest Pain
- □ Claudication (leg pain with activity)
- □ Edema (lower leg swelling)
- □ Palpitations
- □ Orthopnea (shortness of breath when lying down)

### NEUROLOGICAL
- □ NONE
- □ Dizziness
- □ Numbness in Hands/Feet
- □ Weakness in One/Both Arms/Legs
- □ Abnormal Gait (unusual walking)
- □ Headache
- □ Memory Loss
- □ Seizures
- □ Tremors
PERSONAL MEDICAL HISTORY

PULMONARY
- Allergies
- Alpha 1 Antitrypsin
- Asbestos
- Asthma
- Recurrent Bronchitis
- COPD
- Emphysema
- Lung Nodule(s)
- Pneumonia
- Pulmonary Embolism
- Pulmonary Fibrosis
- Sarcoidosis
- Sleep Anea
- Valley Fever (Coccidioidomycosis)

RHEUMATOLOGIC
- Lupus
- Rheumatoid Arthritis

CARDIOVASCULAR
- Anemia
- Atrial Fibrillation
- Blood Clots/DVT
- Chest Pain (Angina)
- Congestive Heart Failure
- Coronary Artery Disease
- Elevated Cholesterol
- High Blood Pressure (HTN)
- Heart Attack (MI)
- Murmur/Heart Valve Disease
- Stroke

GASTROINTESTINAL
- Acid Reflux (GERD)
- Hepatitis, Type: C B A

GENITOURINARY
- Kidney Stones
- Chronic Kidney Disease

NEUROLOGIC/PSYCHOLOGICAL
- Anxiety
- Bipolar Disorder
- Dementia
- Depression
- Insomnia
- Restless Leg Syndrome

METABOLIC
- Diabetes, Type: 1 2
- Hyperthyroidism
- Hypothyroidism

MUSCULOSKELETAL
- Fibromyalgia
- Osteoarthritis

OTHER
- Cancer, Type:
- HIV/AIDS
- Tuberculosis
- Immunoglobulin Deficiency

Additional Medical History

SURGICAL HISTORY

PULMONARY
- Bronchoscopy
- Lobectomy: L R
- Lung Biopsy
- Lung Surgery
- Tonsillectomy
- Adenoidectomy
- Tracheostomy
- Sinus Surgery

CARDIOVASCULAR
- CABG/Open Heart Surgery
- Cardiac Catheterization
- Cardiac Stent
- Pacemaker

GASTROINTESTINAL
- Appendix Removal
- Gall Bladder Removal
- Gastric Bypass
- Hernia Repair
- Dialysis
- Kidney Stone Removal
- Kidney Removal

GENITOURINARY
- Back Surgery
- Hip Replacement: L R
- Knee Replacement: L R
- Neck Surgery
- Rotator Cuff Repair: L R

MUSCULOSKELETAL
- Prostate Surgery
- Cataract Surgery
- LASIK
- Lymph Node Biopsy
- Mastectomy
- Thyroidectomy

FEMALE
- C-Section (Cesarean)
- Hysterectomy
- Tubal Ligation

MALE
- Prostate Surgery

OTHER
- Cataract Surgery
- LASIK
- Lymph Node Biopsy
- Mastectomy
- Thyroidectomy

Additional Surgical History
### FAMILY HISTORY

**PULMONARY**
- Alpha 1 Antitrypsin
- Asthma
- COPD
- Emphysema
- Pulmonary Fibrosis
- Pulmonary Hypertension
- Sarcoidosis
- Sleep Apnea

- Father
- Mother
- Brother
- Sister

**CANCER**
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Other Cancer

- Father
- Mother
- Brother
- Sister

**CARDIOVASCULAR**
- Coronary Artery Disease
- Hypertension
- Venous Thrombosis

- Father
- Mother
- Brother
- Sister

**RHEUMATOLOGIC**
- Rheumatoid Arthritis
- Lupus

- Father
- Mother
- Brother
- Sister

**NEUROLOGICAL**
- Alzheimer’s
- Dementia

- Father
- Mother
- Brother
- Sister

**ENDOCRINE**
- Diabetes

- Father
- Mother
- Brother
- Sister

**SOCIAL**
- Alcoholism
- Drug Abuse

- Father
- Mother
- Brother
- Sister

Additional Family History

### SOCIAL HISTORY

**Do you use Tobacco:**
- Yes
- No
- Former

**Type of Tobacco:**
- Cigarettes
- Cigar
- Pipe
- Chew
- Smokeless

**Overall Daily Average:** pack(s)/pipe/can

**Total # of Years Used:**

**Date Quit:**

**Do you drink Alcohol:**
- Yes
- No
- Former

**Type of alcohol:**
- Beer
- Wine
- Liquor

**How Much:** Beers/Glasses/Drinks

**How Often:** Daily Weekly Monthly Yearly

**Date Quit:**

**Do you drink Caffeine:**
- Yes
- No

**Type of Caffeine:**
- Coffee
- Tea
- Soda
- Energy drinks

**How Much:** cups/ounces

**Do you use Recreational drugs:**
- Yes
- No
- Former

**How Often:** Daily Weekly Yearly

**Date Quit:**

**Do you Exercise:**
- Yes
- No

**Type of Exercise:**

**How Much:**

**How Often:**

**Occupation:**

**Marital Status:**
- Single
- Married
- Life Partner
- Divorced
- Widowed

**Domestic Partner:**
- Opposite Sex
- Same Sex

**# of Years in Arizona:**

**# of Children:**
- Sons
- Daughters

**Pets:**
- Yes
- No

**Type:**


MEDICATION LIST

Name __________________________ Date of Birth __________________________ Date __________________________

Pharmacy __________________________ Location __________________________ Phone Number ______(______)______

Any allergies to medicines: Yes  No  Unknown

If Yes, what medicine(s): __________________________ What reaction(s): __________________________

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICINES, VITAMINS AND SUPPLEMENTS

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength (mg, mcg, etc.)</th>
<th>How Often (1 x day, 2 x day, etc.)</th>
<th>Reason for taking (heart, blood pressure, etc.)</th>
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Authorization to Release Information

The purpose of this form is for YOU (patient) to give Pulmonary Associates permission to release information regarding your care to the Family/Friend listed below. Please review, complete, sign & date and return to our front desk.

(Ex: prescription pick-up, appointment coordination, record retrieval, etc...)

Patient Name: __________________ Date Of Birth: ________ SSN #: __________

I, ____________________________ , authorize Pulmonary Associates, PA to communicate with the person/persons listed below regarding my care and treatment.

<table>
<thead>
<tr>
<th>1. Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>Telephone #: (____)</td>
<td>City/State 85</td>
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</table>

<table>
<thead>
<tr>
<th>2. Name</th>
<th>Address</th>
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</thead>
<tbody>
<tr>
<td>Telephone #: (____)</td>
<td>City/State 85</td>
</tr>
</tbody>
</table>

___ Verbal Communication
___ Other (Please Specify): __________________

The purpose of this release: COORDINATION OF CARE

Pulmonary Associates, PA is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time (in writing) with the exception that action has already been taken on the consent. Unless otherwise specified, this consent expires one year following date of signature.

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization of the release of medical or other Information for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." I understand records or information in the records will not be covered under Federal Privacy Laws should the RECEPIENT of my records re-disclose them. Note: A photocopy and/or facsimile of this consent shall be considered valid as original.

_____________ Patient/Parent/Guardian Signature  

Form to EXPIRE 1 year from original signed date
Pulmonary Associates Office and Financial Policies:

Thank you for choosing Pulmonary Associates, PA. for your medical needs. We are committed to providing you with the highest quality medical care and maintaining a good physician-patient relationship is our primary goal. Even when insurance is in place, patients are ultimately responsible for charges associated with their care. As your provider, we feel it is our responsibility to let you know in advance of our office and financial policies. This will allow for a good flow of communication and enable us to achieve our physician-patient relationship goal. We realize you have choices for your medical care, and we sincerely appreciate you choosing Pulmonary Associates, PA.

For our patient’s convenience, we participate in most major health plans. Our business office will submit claims for services rendered and will assist you in any reasonable way in getting your claims paid. It is the patient’s responsibility to provide all necessary information during the appointment scheduling process as well as ensuring there is an authorization and/or referral form from your PCP if it is required by your insurance.

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

FEES AND SURCHARGES

➤ **$25.00 Fee for No Shows and Late Cancellations (cancelling with less than 24-hrs notice):**
To avoid this fee, please call (602) 258-4951 to cancel or reschedule all appointments within 24 hours of your scheduled appointments. If you are not able to get through or call after business hours, please leave a voicemail of your cancellation.

➤ **$25.00 Fee for Form Completion:**
There will be a fee of $25.00 for all forms needing completion outside an office visit.

➤ **FEES for Processing Medical Records Request Forms:**
- 1-10 pages = $10.00
- 11-20 pages = $15.00
- 21+ pages = $25.00

➤ **Administrative Collection Fees:**
Any outstanding balances sent to a third party collection agency will incur a 20% fee. In addition, you may not be able to make future appointments until this balance is discussed with our billing department.

➤ **$10.00 Surcharge Fee:**
Your insurance requires you to pay your co-payment at the time of service. Failure to pay in full at the time of service will result in a $10.00 surcharge fee.

➤ **$25.00 NSF Fee for Returned Checks:**
All returned checks will incur an additional $25.00 fee, and we will require alternative payment for all future visits.

Please **SIGN** and **DATE** below acknowledging your notification of these fees:

Print Name: _____________________________________________

Signature: ___________________________ Date: ________________