SALEM CHEST SPECIALISTS

PATIENT NAME: _____
FIRST *MIDDLE* *LAST* *MAIDEN*

SEX: M / F (circle) **BIRTHDATE:** _____ **AGE:** _____ **SOCIAL SECURITY NO:** _____

RACE: WHITE_____ BLACK / AFRICAN AMERICAN_____ MORE THAN ONE RACE_____ REFUSED TO REPORT _____

AMERICAN INDIAN/ALASKA NATIVE _____ NATIVE HAWAIIAN_____ OTHER PACIFIC ISLANDER_____ ASIAN_____

PREFERRED LANGUAGE: ENGLISH____ SPANISH____ JAPANESE____ GERMAN____ HINDI____ GREEK____ OTHER

ETHNICITY: NOT HISPANIC OR LATINO_____ HISPANIC OR LATINO _____ REFUSED TO REPORT/UNREPORTED_____

ADDRESS: _____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

TELEPHONE: HOME: _____ **WORK:** _____ **CELL:** _____

EMAIL:_____

EMPLOYED BY:_____ **PHONE:**_____

SPOUSE'S NAME:_____ **SPOUSE'S SS#:**_____

SPOUSE'S DOB:_____ **PHONE:**_____

REFERRING PHYSICIAN:_____ **PHONE:**_____
NAME

PRIMARY CARE PHYSICIAN:_____ **PHONE:**_____
NAME

PHARMACY INFORMATION:_____ **PHONE:**_____
NAME

DURABLE MEDICAL EQUIPMENT COMPANY CURRENTLY USED

(CPAP, OXYGEN, NEBULIZERS OR OTHER EQUIPMENT/SUPPLIES)_____

EMERGENCY CONTACT INFORMATION

NAME:_____ **PHONE:**_____
SOMEONE NOT AT SAME ADDRESS AS YOU

INSURANCE AUTHORIZATION & RELEASE OF INFORMATION

I HEREBY AUTHORIZE AND REQUEST MY INSURANCE COMPANY, INCLUDING MEDICARE/CHAMPUS, TO PAY SALEM CHEST SPECIALISTS THE AMOUNT DUE ON MY CLAIM FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I FURTHER AGREE THAT SHOULD THE AMOUNT BE INSUFFICIENT TO COVER THE ENTIRE MEDICAL EXPENSE, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. IF THE NATURE OF THE DISABILITY BE SUCH THAT IT IS NOT COVERED BY THE POLICY, I WILL BE RESPONSIBLE TO SALEM CHEST SPECIALISTS FOR PAYMENT OF THE ENTIRE BILL. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENTS OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE COMPLETE AND ACCURATE INSURANCE INFORMATION, INCLUDING ANY UPDATES OR CHANGES IN COVERAGE. SHOULD I FAIL TO PROVIDE THIS INFORMATION AND INSURANCE IS FILED INCORRECTLY AS A RESULT, I UNDERSTAND THAT I WILL BE FINANCIALLY RESPONSIBLE.**

I UNDERSTAND IT IS THE POLICY OF SALEM CHEST SPECIALISTS THAT PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED INCLUDING HMOs, PPOs, MEDICARE AND MEDICAID CO-PAYMENTS AND/OR DEDUCTIBLES. EXCEPTIONS TO THIS POLICY MUST BE ARRANGED IN ADVANCE WITH THE PATIENT'S ACCOUNT MANAGER. ACCOUNT BALANCES OVER NINETY (90) DAYS ON WHICH NO PAYMENT HAS BEEN MADE MAY BE SUBJECT TO COLLECTION ACTIVITY.

I UNDERSTAND THAT SALEM CHEST SPECIALISTS RESERVES THE RIGHT TO CHARGE A FEE FOR NOT SHOWING UP FOR APPOINTMENTS.

SIGNATURE:_____ **DATE:**_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Salem Chest Specialists Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the right to request restrictions concerning the use of my information. I request the following restrictions:

_____

_____

With whom we may discuss your treatment other than your physicians?

Name: _____ *Relationship:* _____ *Phone:* _____

Name: _____ *Relationship:* _____ *Phone:* _____

With whom may we discuss your payment (if different from above)?

Name(s): _____

Signature: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient:

Relationship: _____ *Witnessed by:* _____

INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on: _____ _____

Date *Time*

By: _____

Name and Title

SALEM CHEST SPECIALISTS

SALEM CHEST SPECIALISTS

3001 LYNDHURST AVE
WINSTON SALEM, NC 27103
Phone: (336) 765-0383
Fax: (336) 768-1737

Name: Date:

Date of Birth: Primary Care MD:

Date last seen by above MD:_____

Please list the names of Physicians/Specialists you routinely see/ have seen in past:

_____

_____

_____

Please answer the following?:

Smoker:number of year(s) _____ pack(s) per day _____

Former Smoker:year quit _____ year(s) smoked _____ pack(s) per day _____

Never Smoked? Y or N

Alcohol Use? Y or N

If yes, how much?: _____

Illicit Drug Use? Y or N

If yes, please specify: _____

Caffeine Use? Y or N (soda, coffee, tea)

If yes, how much?: _____

Occupation? Full Time, Part Time, or Retired

What is/was your type of work?: _____

Marital Status?: Single, Married, Divorced, or Widowed

Pets? Y or N

If yes, please specify?: _____

List serious illnesses, surgical operations, hospitalizations in the past with dates:

1. 5.
2. 6.
3. 7.
4. 8.

	Age	Disease	(W)ell(S)ick(D)ead		Age	Disease	(W)ell(S)ick(D)ead
Father				M F			
Mother				Spouse			
Siblings M F				Child M F			
M F				M F			
M F				M F			

Circle if any blood relative had:

1. Asthma
2. Emphysema
3. Lung cancer
4. Colon cancer
5. Ovarian cancer
6. Breast cancer
7. Heart disease
8. Stroke
9. Tuberculosis
10. Diabetes
11. Cystic Fibrosis

Please circle any of the following problems you have had recently:

General:
Appetite Loss, Fatigue, Fever/Chills, Night Sweats, Weight Gain, and Weight Loss.

Skin:
Change in Wart/Mole, Itching, and Rash.

Eyes/Ears/Nose/Throat:
Blurred Vision, Glaucoma, Visual Loss, Hearing Loss, Nose Bleed, Nasal Congestion, Seasonal Allergies, Hoarseness, Oral Ulcers, Sore Throat, Voice Changes, and Choking Sensation.

Neck:
Neck Pain and Swollen Glands.

Cardiovascular:
Calf Cramps, Chest Pain, Difficulty Breathing Lying Down, Elevated Blood Pressure, Heart Stent, Leg Pain and/or Swelling, Palpitations, Phlebitis and Swelling of Extremities.

Gastrointestinal:
Abdominal Pain, Black Tarry Stool, Bloody Stool, Diarrhea, Difficulty Swallowing, Heartburn, Indigestion, Nausea, and Vomiting.

Female Genitourinary:
Blood in Urine, Frequency, Incontinence, Kidney Stones, Menstrual Irregularities, Painful Urination, and Vaginal Discharge

Musculoskeletal:
Arthritis, Back Pain, Joint Pain, and Muscle Weakness

Neurology:
Decreased Memory, Excessive Daytime Sleepiness, Fainting, Headaches, Seizures, Snoring, Stops breathing at night, Stroke and Trouble Walking.

Psychiatric:
Anxiety, Depression and Insomnia.

Endocrine:
Cold Intolerance, Excessive Thirst, Excessive Urination, Heat Intolerance and Thyroid Problems.

Hematology:
Anemia, Blood Clots, Easy Bruising, Enlarged Lymph Nodes and Excessive Bleeding.

I certify that the above information is correct to the best of my knowledge:

_____

Patient Name: _____ Date: _____

SLEEP FACTS

Do you have a history of snoring?

- o Never
- o Sometimes— occasionally or under special circumstances
- o Every night or almost every night
- o Do not know

Has your bed partner ever moved, temporarily or permanently, to another bedroom (or had you move to another bedroom) due to snoring or restless sleep?

- o Yes
- o No

Have you ever been told you seem to have momentary periods of sleep when you stop breathing or breathe abnormally?

- o Yes
- o No

Do you ever gasp for air during the night?

- o Yes
- o No

Have you ever been told you kick during your sleep?

- o Yes
- o No

Do you have a family history of sleep apnea?

- o Yes
- o No

How sleepy are you now on a scale of 1 — 10?
Please circle the number (1 = not sleepy and 10 = very sleepy)

1 2 3 4 5 6 7 8 9 10

Epworth Sleepiness Scale

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: (0 — 3)
Sitting and Reading	_____
Watching TV	_____
Sitting inactive in a public place (theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total Score (add up the numbers) **This is your Epworth Score:** _____