

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

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.

Genitourinary:

Blood in Urine, Change in Urinary Stream, Kidney Stones, Penile Lesions, Testicular Mass, Testicular Pain, and Excessive Urination at Night

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?

- Never
- Sometimes— occasionally or under special circumstances
- Every night or almost every night
- 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?

- Yes
- No

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

- Yes
- No

Do you ever gasp for air during the night?

- Yes
- No

Have you ever been told you kick during your sleep?

- Yes
- No

Do you have a family history of sleep apnea?

- Yes
- 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
- Chance of Dozing: (0 — 3)

Situation:

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:
