





Name: \_\_\_\_\_  
 Email: \_\_\_\_\_

DOB: \_\_\_\_\_  
 PHONE: \_\_\_\_\_

**Preferred Pharmacy:**

Name of Pharmacy: \_\_\_\_\_  
 Location (Street/City/State): \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Current Medical Conditions: CHECK ALL THAT APPLY**

Numbness in limbs	Difficulty swallowing	Swelling in feet/ankles	Other(s):
Ear aches	Excessive thirst	Cough	
Double/blurred vision	Swelling of legs	Skin rash	
Abdominal pain	Night sweats	Trouble sleeping	
Leg pain	Snoring	Weight loss	
Bloody bowels	Shortness of breath	Nose bleeds	
Painful urination	Chills	Vomiting	
Frequent urination	Coughing up blood	Diarrhea/Constipation	

**Personal Medical History: CHECK ALL THAT APPLY**

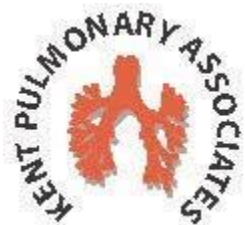
Anemia	COPD	HIV/AIDS	Seizures/Epilepsy
Anxiety	Diabetes	Hyperthyroidism	STD
Arrhythmia	Diverticulitis	Joint Pain	Stroke
Arthritis	Headaches	Mental Illness	
Asthma	Heart Attack	Numbness in Extremities	Swelling of Extremities
CHF	Heart Murmur	Pacemaker	Other(s)
Chronic Pain	Heart Palpitations	Renal Disease	
Claudication	High Blood Pressure	Seasonal Allergies	

**Procedures & Surgeries:**

Procedure	Date (s)	Procedure	Date (s)

**Family History: CHECK ALL THAT APPLY**

	Mother	Father	Maternal Grandmother	Maternal Grandmother	Paternal Grandmother	Paternal Grandfather
Alcoholism						
Allergies						
Anemia						
Asthma						



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Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Osteoporosis						
Stroke						
Thyroid Disease						
Other(s)						

**Social History:**

Are you currently employed? Yes/No

If so, where are you currently employed? \_\_\_\_\_

Alcohol Use: Current/Past/Never

How often do you currently drink alcohol? \_\_\_\_\_

If you no longer consume alcohol, how often would you consume alcohol? \_\_\_\_\_

Tobacco Use: Current/Past/Never

How many years have you used tobacco products? \_\_\_\_\_

If you have quit, how many years has it been since you have quit? \_\_\_\_\_

What tobacco products did you use? CHECK ALL THAT APPLY

Cigarettes Cigars Oral Pipe Other: \_\_\_\_\_

Drug Use: Current/Past/Never

List Drug Use Current and Past:

\_\_\_\_\_



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**Patient Communication Permission:**

Permission to leave voicemails on answering machine  
Appointment Yes/No      Medical/Refills Yes/No

Permission to speak to a family member Yes/No  
If so, list name(s) and relationship(s) of whom we may speak with: \_\_\_\_\_

**Authorization/Assignment of Benefits:**

I give permission to Kent Pulmonary Associates and its employees, agents, and medical providers to release medical information to insurance carriers, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me, to be directed to or appropriate provider. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical service provided. I understand that my medical information may be electronically submitted to any or all treating physicians, hospitals, any/or healthcare entities. I permit a copy of this authorization to be used in place of the original.

**Financial Policy Acknowledgment:**

I hear by acknowledge that I have fully reviewed and understood the Financial Policy provided to me. Furthermore, by signing below, I agree to comply to Kent Pulmonary Associates financial policy.

**HIPPA Privacy Acknowledgement:**

I hear by acknowledge that I have reviewed and understood the Notice of Privacy Practices provided to me by Kent Pulmonary Associates.

**Telemedicine Acknowledgment and /or CPAP/Vent Remote monitoring consent**

I hear by acknowledge that I have reviewed and understood the Telemedicine/CPAP Remote Monitoring Consent and Disclosure provided to me by Kent Pulmonary Associates.

“I have read the Authorization/Assignment Benefits, Financial Policy, Notice of Privacy Practices, and Telemedicine Consent and Disclosure and CPAP Remote Monitoring.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_



Name: \_\_\_\_\_

Email: \_\_\_\_\_

Patient Signature

DOB: \_\_\_\_\_

PHONE: \_\_\_\_\_

Date