New Patient Packet

Name:_____ Date of Birth:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Phone Number(s): Home: _____ Cell: _____ Work: _____
Social Security Number: _____ Sex: Male/Female/Other: _____ Race: _____
Primary Care Physician: _____ Phone Number: _____
Referring Physician: _____ Phone Number: _____
Reason for visit: _____
Do you use a CPAP machine to sleep at night? Yes/No
If so, who is your supply company?: _____

Emergency Contact:
Name: _____ Relationship: _____Phone Number: _____

Insurance Information:
Primary Insurance: _____ Policy ID Number: _____
Group Number: _____Guarantor: _____ Relationship: _____

Secondary Insurance: _____ Policy ID Number: _____
Group Number: _____Guarantor: _____ Relationship: _____

Would you like receive access, via email, to your online patient portal? Yes/No
If so, provide the following information:
Email:_____ Last 4 digits of SSN: _____
You will receive a link to the email listed above 24-48 hours after your visit. The link will bring you to your IQ Health Portal. The last 4 digits of your SSN will allow you temporary access to your records. It is your responsibility to create your account.

Do you have any known allergies? Yes/No If so, list all known allergies: _____

Medication(s): Are you currently on any medications? Yes/No
If so, list the name of the medication along with its corresponding dosage and frequency below.

Medication Name	Dosage	Frequency

Name: _____ DOB: _____
Email: _____ 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						

Name: _____ DOB: _____
Email: PHONE:

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:
_____

Name: _____ DOB: _____
Email: _____ PHONE: _____

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: _____ DOB: _____

Email: _____ PHONE: _____

Patient Signature: _____ Date:_____

Kent Pulmonary Associates

Patient Allergy Screening

ALLERGY HISTORY

Patient Name:_____ Date: ____/____/____

Physician:_____

Please check the following which apply:

1. Family History:

□ Asthma	□ Eczema	□ Sinus problems	□ Migraine
□ Hay fever	□ Ulcer	□ Nervous disorder	□ Colitis

□ Other:_____

2. Do you wheeze sometimes? _____ Yes _____ No
3. Do you have asthma/allergies? ____ Yes _____ No
4. Do you cough frequently? _____ Yes _____ No

5. Are your symptoms made worse by:

□ Wind	□ Smoke	□ Barns/Hay	□ High pollution day
□ Damp areas	□ Powder	□ Mowing lawns	□ Air-conditioning
□ Insecticides	□ Dust	□ Paint fumes	□ Perfumes
□ Cosmetics	□ Newspapers	□ Wool	□ House plants
□ Weather change	□ Wet weather	□ Dry weather	□ Hot day
□ Cold day			

6. Do you have pets or are you exposed to other animals?

□ Cats □ Dogs □ Cockatiels/Birds

□ Other, list: _____

7. Are you currently or have you ever been exposed to mold? ____ Yes_____ No
8. Do you have carpet in your dwelling? _____ Yes _____ No
9. Are you currently taking allergy medications? _____ Yes _____ No
10. Have you taken prednisone (oral steroids) in the past? _____ Yes _____ No
11. Would you consider being tested for common allergies? _____ Yes _____ No

Patient Signature:_____