PULMONARY ALLERGY CRITICAL CARE & SLEEP ASSOCIATES

M. WAEL AL-AMERI, M.D., F.C.C.P.
ROBERT O. GO, M.D., F.C.C.P.
MUHAMMAD KASHLAN, M.D., F.C.C.P., F.A.A.S.M.
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TINA ABRAHAM, D.O.

NEW PATIENT PAPERWORK INSTRUCTIONS

Please bring in your completed new patient registration forms, as well as your driver's license and insurance cards, to your initial visit in our office.

Patient Information

On the first page, fill in all the blanks that apply.

On the second page, sign and date the statements that apply. Under the "Optional" section is where you can list the names of individuals that you would like to be authorized for us to release your medical information to.

Patient Assessment Form

Fill in this page to the best of your knowledge.

Under smoking, specify how much you smoke per day and for how long you have smoked. If you have quit, please note how much you did smoke per day and how many years you had smoked for, as well as when you quit.

Medication Profile

If you already have your own list, there is no need to complete this page; please bring a copy of your list in with you for your visit. Otherwise, a list is provided here for you.

Medical Release Form

For this page, please enter your name, date of birth, and signature ONLY. This form allows us to request test results that you may have had elsewhere that is pertinent to your care.

HIPAA Notice of Privacy

Read through our HIPAA Notice of Privacy Practices. Signature and date acknowledging the HIPAA privacy rules are on the Patient Information form.

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DATE: ____________________

Please indicate how you were referred to our office:

☐ Friend ☐ Relative ☐ Physician (name) ____

PATIENT INFORMATION:

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Indian ☐ White ☐ Decline ☐ Other __________

Patient Name: __________________________________ Date of Birth: _________________

Social Security #: ____________________ Gender: ☐ Male ☐ Female Marital Status: M S W D

Address: ____

City: _________________________________ State: __________ Zip Code: ______________

Primary Phone #: ______________________ Alternate Phone #: ________________________

Email Address: ____

EMPLOYER:

Employer: _____________________________________ Phone #: _______________________

Address: ____

SPOUSE:

Name: ____ Date of Birth: _________________

Social Security #: _______________________________

Employer: _____________________________________ Phone #: _______________________

Address: ____

REPONSIBLE PARTY (if patient is a minor)**:**

Name: ____ Relationship: _________________

Address: _______________________________________ Phone #: _______________________

EMERGENCY CONTACT:

Name: ____ Phone #: _______________________

Relationship: ___________________________________

SECONDARY CONTACT:

Name: ____ Phone #: _______________________

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PLEASE READ AND SIGN THE FOLLOWING STATEMENTS:

I hereby authorize the release of medical information to insurance carriers concerning benefits payable for services rendered and I hereby assign to the doctor all payment for medical services rendered to my dependent or me. I understand I am responsible for any amount not covered by my insurance.

It is your responsibility to know your individual coverage. Failure to comply with our suggestion could result in you being responsible for all the cost incurred.

SIGNATURE: ______________________________ DATE: ________________

MEDICARE ONE TIME DIRECTION OF PAYMENTS:

I give my permission for my provider to bill Medicare and receive payment for my medical care. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Health Care Financing Administration (HCFA) is the government Medicare agency.

MEDICARE BENEFICIARY SIGNATURE: ______________________________

DATE: ________________

OPTIONAL:

Authorization for the disclosure of protected health information including, but not limited to scheduling/referral information, test results, medical instructions, and billing information.

List the names of the party or parties authorized to receive protected information concerning your health care and treatment:

Name(s):

1. ______________________________ Relationship: ________________

2. ______________________________ Relationship: ________________

SIGNATURE: ______________________________ DATE: ________________

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have read and understand the “Notice of Privacy” in accordance to HIPAA law for Pulmonary Allergy Critical Care and Sleep Associates (PACCSA). I am also aware that I may request a copy of the “Notice of Privacy” at any time. I understand and agree to the provisions as stated above.

SIGNATURE: ______________________________ DATE: ________________

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PATIENT ASSESSMENT PROFILE

Patient Name: ______________________ Age: _______ Sex: ☐ M ☐ F Date: ____________

Referred By: ______________________ Pharmacy Name/Phone: ______________________

Chief Complaint: ____

History of Present Illness: ____

Past Medical History (***check all that apply***):

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Cancer
  Type: ____________
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Sinus Trouble
- ☐ Thyroid Problem
- ☐ Kidney Problem
- ☐ Diabetes Mellitus
- ☐ Arthritis
- ☐ Seizures
- ☐ Venereal disease
- ☐ Drug Abuse
- ☐ Tuberculosis

Previous Surgeries: ____

Smoking: ☐ Y ☐ N Packs/Day? ________ How Long? ________ Quit? _____ If yes, when? _____

Drinking: ☐ Y ☐ N How Much? ________ How Long? ________ Quit? _____ If yes, when? _____

Occupation/Employment: ____

Industrial Exposure: ____

Household Pets: ____

Review of Symptoms (***check all that apply***):

- ☐ Chest Pain
- ☐ Cough
- ☐ Sputum/Phlegm
- ☐ Cough Blood
- ☐ Short of Breath
- ☐ Fever
- ☐ Night Sweats
- ☐ Nasal Congestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Bloody Nose
- ☐ Weight Loss
- ☐ Headache
- ☐ Dizziness

Family History:

	State of Health
Mother	
Father	
Brother	
Sister	

Patient Allergy History:

Allergy	Type of Reaction	When

75 Barclay Circle, Suite 205 • Rochester Hills, Michigan 48307 • (248) 651-6430
1083 Suncrest Drive, Suite B • Lapeer, Michigan 48446 • (810) 667-3111
1540 Lake Lansing Road, Suite 205 • Lansing, Michigan 48912 • (517) 853-5550

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT AUTHORIZATION:

Name: ______________________________ Date of Birth: ______________

Signature: ______________________________ Date: ______________

FOR OFFICE USE ONLY

INFORMATION TO BE RELEASED FROM (*select only one*):

- ☐ Pulmonary Allergy Critical Care & Sleep Associates
- ☐ Organization, Physician, or Provider: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip Code: ________

Phone: ______________ Fax: ______________

INFORMATION TO BE RELEASED TO (*select only one*):

Pulmonary Allergy Critical Care & Sleep Associates

☐ Rochester Location
75 Barclay Circle
Suite 205
Rochester Hills, MI 48307
Phone: 248-651-6430
Fax: 248-650-1382

☐ Lapeer Location
1083 Suncrest Drive
Suite B
Lapeer, MI 48446
Phone: 810-667-3119
Fax: 810-667-3119

☐ Lansing Location
1540 Lake Lansing Road
Suite 205
Lansing, MI 48912
Phone: 517-853-5550
Fax: 517-485-1490

☐ Organization, Physician, or Provider: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip Code: ________

Phone: ______________ Fax: ______________

WHAT KIND OF INFORMATION TO BE RELEASED:

- ☐ All Records
- ☐ Information from Specified Date Range: ____/____/_____ to ____/____/______
- ☐ Specific Information
  - ☐ Office/Progress Notes
  - ☐ PFT
  - ☐ Chest Imaging
  - ☐ Oximetry Study
  - ☐ Sleep Study
  - ☐ Other ______________________________

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MEDICATION PROFILE

Name: ____ DOB: ____________________________

Drug Allergies (examples: sulfa drugs, penicillin)	Reaction (examples: rash, rives, nausea, vomiting)
1.	
2.	
3.	
4.	
5.	

Name of Medication (prescriptions, over-the-counter, eye drops, supplements, patches, inhalers)	Dose of Medication (example: one 20mg tablet)	How Often Do You Take This Medication? (examples: three times a day, at bedtime)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

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