EAST VALLEY
Pulmonary Associates

PATIENT REGISTRATION FORM

Today's Date: _____/_____/_____

(PLEASE PRINT and FILL OUT ALL FORMS COMPLETELY)

Patient Name: _____ Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Email: _____

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino __ Declined

Race: □ Native American or Alaska Native □ African or African American □ Asian or Asian American
□ Caucasian or European American □ Native Hawaiian or Other Pacific Islander □ Declined

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Partner

Emergency Contact: _____ Ph # _____

PCP: _____ Ph # _____ Fax # _____
Primary Care Doctor

Pharmacy Name: _____ Ph # _____
Cross Streets

Pharmacy Insurance:_____ **ID#:**_____ **Phone#:** _____

****

Primary Insurance: _____ Effective Date: _____ / _____ / _____

Member / Policy #_____ Group # _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Date of Birth: _____ / _____ / _____ Policy Holder's Employer: _____

****

Secondary Insurance: _____ Effective Date: _____ / _____ / _____

Member / Policy #_____ Group # _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Date of Birth: _____ / _____ / _____ Policy Holder's Employer: _____

****

Acknowledgement: I certify that the above information is true and correct. I hereby authorize release of any and all medical information that may be requested by the above named insurance carrier(s) in order to process a claim for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges accumulated from any missed appointments that were not cancelled by the patient at least 24 hours prior to my scheduled appointment. In the event of default and the account is placed with a collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed with the agency and interest accrual of 10% per year on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs that occur.

Patient Signature: _____ Date: _____ / _____ / _____

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Medical History Form

Patient Name: _____ Date of Birth: _____ / _____ / _____

Advanced Directives:

Do you have an Advanced Medical Directive / Living Will? □ Yes □ No

Social History:

Do you smoke? □ Yes □ No Packs/day_____ How many years? _____

Did you ever smoke? □ Yes □ No Packs/day_____ How many years? _____

Have you ever quit? □ Yes □ No If Yes, when and for how long did you quit? _____

How did you quit? _____

Do you use tobacco products other than cigarettes? □ Yes □ No Which ones? _____

Does anyone smoke in your household? □ Yes □ No

Do you drink alcohol? □ Yes □ No If Yes, amount per week? _____

Have you ever used illegal substances? □ Yes □ No

Have you ever had a DUI or DWI? □ Yes □ No

Have you ever experienced difficulty with alcohol, drugs or other substance use? □ Yes □ No

Hobbies: □ Hiking □ Biking □Carpentry □ Other (Please list any activities that involve exposure to outdoors)

_____

_____

Pets: □ Dogs □ Cats □Birds □ Other _____

Do you take care of birds (pigeons, chickens)? □ Yes □ No

Recent travel (Where **outside** of the US) _____

_____

Where did you grow up? _____

How long have you lived in the Phoenix area? _____

Do you live on a farm? □ Yes □ No

Occupational History: Current occupation _____

Exposure to: □ Asbestos □ Fumes □ Dust

(Please list previous occupations-include approximate dates of employment)

1. _____ 2. _____

3. _____ 4. _____

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Medical History Form

Patient Name: _____ Date of Birth: _____ / _____ / _____

List all Physicians you see on a regular basis and reason:

1. _____ 2. _____
3. _____ 4. _____

List All and Current Health Problems □ NONE	Date Started

List all Lifetime Surgeries □ NONE	Date

Family History (blood related Kin) □ Adopted or do not know family history

If your mother or father is deceased, what caused his/her death? M: _____ F: _____

If any of your siblings are deceased, what caused his/her death? _____

Please check if any of the following apply to blood related kin, Indicate which family member(s):

□ COPD / Emphysema _____ □ Asthma _____
□ Tuberculosis (TB) _____ □ Cancer (what type)? _____
□ Heart disease _____ □ Diabetes _____
□ Sleep disorders _____ □ Bleeding/Clotting problem _____
□ Other Lung diseases (specify) _____

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Patient Name: _____ Date of Birth: ____/ _____/ _____

Review of Symptoms

Do you CURRENTLY or FREQUENTLY suffer from or have the difficulty with any of the below? Please check box(es):

GENERAL □ None listed below

□ Unusual fatigue □ Loss of appetite □ Fever or chills □ Night sweats (drench sheets/clothes)

□ Weight loss _____ lbs Time frame? _____ □ Weight gain_____ lbs Time frame? _____

EARS, NOSE, THROAT, MOUTH □ None listed below

□ Headache □ Ear pain / pressure □ Sinus problems, post nasal drip □ Hoarseness □ Frequent clearing of throat

□ Ulcer of tongue or mouth □ Sore throat

SKIN/ALLERGIC □ None of the above

□ Hay fever □ Frequent sneezing □ Watery eyes □ Seasonal allergies □ Skin Rash □ Skin Tumor

CARDIOVASULAR (RESPIRATORY) □ None listed below

□ High blood pressure □ Chest pain of exercise (angina) □ Irregular beat or palpitation of heart

□ Heart murmur □ Swelling or edema of ankles □ History of heart attack □ History of enlarged heart (CHF)

LUNGS (RESPIRATORY) □ None listed below

□ Asthma, wheezing □ Cough for more than 3 weeks □ Cough, new problem □ Cough up blood

□ Chest tightness or discomfort □ Tuberculosis / PPD+ (positive skin test) □ COPD / Emphysema

□ Recurrent bronchitis □ Shortness of breath (SOB) □ Exposure to asbestos or other occupational hazard

□ Required life support/mechanical ventilation (respirator)

HEMATOLOGIC □ None listed below

□ Easy bleeding/bruising □ Anemia (low blood count) □ Ever had a blood clot in legs or lungs □ Blood transfusion

ENDOCRINE/LYMPHATIC □ None listed below

□ Increased thirst/hunger □ Sensitive to heat/cold □ Change in skin/body/hair □ Swollen lymph nodes anywhere

MUSCLES AND BONES □ None listed below

□ Pains or swelling of joints □ Morning stiffness □ Leg or arm swelling □ Arthritis □ Sexually transmitted diseases

RHEUMATOLOGIC □ None listed below

□ Hair loss □ Joint pain/swelling □ Muscle pain/weakness □ Back/neck pain □ Jaw pain or pain when chewing

□ Sharp pain with deep breathing (pleurisy) □ Dry eyes/irritation, dry mouth □ Fingers that turn white/hurt in the cold

URINARY, STOMACH, AND BOWELS □ None listed below

□ Blood in urine □ Kidney or bladder problems □ Difficult or painful swallowing □ Acid reflux ("Heartburn")

□ Regurgitation □ Belching □ Hiatal hernia □ Stomach/Intestinal ulcer □ Abdominal pain □ Nausea or vomiting

□ Vomit blood/Black bowel syndrome □ Blood or mucous in the stool □ Liver disease □ Hepatitis □ Jaundice

NEUROLOGICAL/SLEEP □ None listed below

□ Snoring □ Stop breathing when sleeping □ Fall asleep easily during the day

□ Anxiety □ Depression □ Unusual dizziness, fainting, or loss of consciousness

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Patient Name: _____ Date of Birth: ____/ ____ / ____

Medication List □ NONE

Name of Medication	Dosage	How often do you take it	Date Started

Check if you use any of the following devices: □ NONE

□ Oxygen-Flow rate _____ l/min How often? _____ Date started: _____

□ CPAP or □ BIPAP (Pressure _____cm H2O) Date started: _____

□ Spacer with inhaler (Aerochamber, Ellipse, Inspires, etc.) Date started: _____

□ Nebulizer (breathing treatment via SVN machine) Date started: _____

Allergies to Medications or Other □ NONE

Name of Medication/Other	Type of Reaction	Date Started

Immunizations:

□ Flu shot (influenza) Date: _____ □ Pneumovax Date: _____

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Patient Name: _____ Date of Birth: ____/ _____ / ____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

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
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre 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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

Score:
0 – 10 Normal range
10-12 Borderline
12-24 Abnormal

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PRACTICE EXPECTATIONS

We are a specialty practice and we see our patients by referral from their Primary Care Physician (PCP) or as a follow-up to a hospital admission. As a specialist, we do not coordinate primary care activities for our patients. Please contact your Primary Care Physician (PCP) for assistance **obtaining follow-up referrals, completion of disability claim paperwork, and completion of work release or light duty requests**. We do not provide laboratory testing or imaging study results by telephone, we do not accept worker's compensation insurance, we **do not** prescribe Narcotics or Anxiolytics, and please contact your pharmacy to request prescription refills.

PAYMENT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Payment for services is due at the time of the visit. We accept cash, check, or credit card (Visa, Mastercard, and American Express). Patients are responsible for their health care charges and should be familiar with their insurance policy. Please be aware of your co-pay amounts, which will be due at the time of your visit. If you need further information, please ask to speak with the Billing Specialist who is available to answer questions and provide assistance.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to East Valley Pulmonary Associates, PLLC. I authorize Easy Valley Pulmonary Associates, PLLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Patient Signature: _____ Date: _____ / _____ / _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND HEALTH INFORMATION NOTICE

I acknowledge that I have been provided the East Valley Pulmonary Associates PLLC. ("EVPA") Notice of Privacy Practices:

- It tells me how EVPA with use my health information for the purposes of my treatment, payment for my treatment and EVPA's health care operations.
- The notice explains in more detail how EVPA may use and share my health information for other than treatment, payment, and health care operations.
- EVPA will also use and share my health information as required/permitted by law.

I acknowledge that I have been provided the East Valley Pulmonary Associates PLLC. (EVPA) Notice of Health Information:

- It tells me how EVPA will electronically share health information with a Health Information Organization (HIO)
- The notice explains in more detail how I may Opt-out of sharing my health information with the HIO.

_____ _____

Signature of Patient or Personal Representative Date

Please refer to our practice website for additional practice information, including normal office hours, www.evpaclinic.com

EAST VALLEY
Pulmonary Associates

East Valley Pulmonary Associates, PLLC.
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Brittany Morgan, DNP, RN, FNP-C
2055 E Southern Ave Ste. C
Tempe, AZ 85282
Phone# 480-626-8737
Fax# 480-704-4698

Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

_____

Telephone: _____

I authorize **East Valley Pulmonary Associates** to disclose/release the following information:

_____ All medical records related to (specify condition, treatment, etc.): _____

_____ All billing records related to (specify condition, treatment, etc.): _____

_____ Specific records/information as follows: _____

_____

Purpose of disclosure: _____

I do not want the following information disclosed (as defined by applicable state and federal laws):

_____ Alcohol/Drug Abuse _____ HIV Test Results _____ Mental Health/Developmental Disabilities

Release information TO:

Address: _____

_____

Telephone: _____ **Fax:** _____

This Authorization is good until the following date: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Address

_____ _____
Description of Personal Representative's Authority Telephone