TARRANT PULMONARY ASSOCIATES
PATIENT FORM

Phan Nguyen MD

3602 Matlock Rd, Suite 206
Arlington, TX 76015
Tel. (682) 323 7006
Fax. (888)720 1899

Patient Name:

Referring Physician:

You have been scheduled for an initial consultation or hospital follow-up appointment with **Dr. Phan Nguyen** on _____

Below is a list of important information to assist you in preparing for this appointment.

- Please complete the enclosed packet of paperwork prior to your appointment. Be sure that all highlighted lines have a signature. The HIPAA privacy information is available in our office for your review if you are not already familiar with its contents.
- It is very important that the doctor have any old and new chest x-rays, CT chest scans or PET scans (**patient must bring the reports**) for this appointment. (This does not apply to hospital follow-up patients.)
- Please have your referring physician fax to our office or send with you any recent office notes and lab work.
- You must bring all your current medications with dosage and frequency. You may bring the medication bottles if you prefer, and the clinical staff can list them in your chart.
- New patients should plan to be in the office for a period of two hours. Patients seen in follow-up after hospitalization should plan approximately one hour for the appointment.
- If your insurance requires a referral, please make sure your referring physician has this completed and faxed to our office prior to your appointment.
- Many of our patients have sensitive respiratory conditions. Please avoid use of scented body spray, perfume, cologne, aftershave, or anything with a heavy scent.
- As a courtesy to our patients, we file charges to your insurance, but all co-payments are expected at the time of service.
- **If you cannot keep your appointment, please call us at (682) 323-7006 as early as possible. Please help us serve you better by keeping scheduled appointments**.

We look forward to meeting you at your first office visit. If we can assist you with questions prior to your visit, please feel free to call. You may also see our website at www.tarrantpulmonary.com for answers to questions you may have.

Tarrant Pulmonary Associates

Scheduling Team

TARRANT PULMONARY ASSOCIATES
PATIENT FORM

Date: _____

SSN _____ Gender _____ Birth date _____ Marital Status _____

Name: _____
First Middle Last Preferred Name

Address: _____
Street City State Zip

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email: _____

Ethnicity:

☐ Latino/Hispanic ☐ Asian ☐ Black/African American
☐ White ☐ Other ☐ Decline to Answer

Employment Status:

☐ Employed ☐ Disabled
☐ Self Employed ☐ Retired
☐ Unemployed ☐ Student

Employer Name: _____ Employer Phone #: _____

Preferred contact method for automated appointment reminders (select one or more):
☐ Voice (Home Phone) ☐ Text (Mobile Phone)
☐ Email ☐ Do Not Remind Me

Patient Portal Access (please select one):

☐ Please **email** an invitation to the patient portal. ☐ I decline access to the patient portal.

Referred By _____ Phone _____ Fax _____

Address: _____
Street City State Zip

Primary Care Physician _____ Phone _____ Fax _____

Address: _____
Street City State Zip

List other physicians you are currently seeing: _____

Are you currently residing in a skilled nursing facility? ☐ Yes ☐ No.

** If yes, name of facility _____

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Notify in case of emergency:

Name _____ Phone _____ Relationship _____

Address _____
Street City State Zip

Pharmacy _____ Phone _____

Have you signed a:

Living Will: ☐ Yes ☐ No

DNR (Do Not Resuscitate): ☐ Yes ☐ No (**Please provide a copy)

Durable Power of Attorney: ☐ Yes ☐ No Date Signed: _____ (**Please provide a copy)

Are you currently using a DME (Durable Medical Equipment) company? ☐ Yes ☐ No

If **yes**, which one? _____

If **no**, who does your insurance company require you to use? _____

Who does your insurance company require you to use for: Lab: _____ X-ray: _____

Is this a work-related illness/injury? ☐ Yes ☐ No

Date of illness/injury: _____ Date last worked: _____

Cause of accident if any _____

_____

I hereby authorize release of my medical records from _____ to **Tarrant Pulmonary Associates**. This authorization expires upon written notice from patient/patient representative.

_____ _____

Signature of Patient or Responsible Party Date

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Patient Information:

Patient Name: _____

DOB: _____

Primary Insurance Policy:

Insurance Co: _____ Insurance ID#: _____

Group #: _____ Effective Date: _____

Copay: _____ Deductible: _____ Deductible Met: _____

Secondary Insurance Policy:

Insurance Co: _____ Insurance ID#: _____

Group #: _____ Effective Date: _____

Copay: _____ Deductible: _____ Deductible Met: _____

Referral Information:

Referral Number: _____

Referral Required: _____

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PATIENT QUESTIONNAIRE:

Patient Name: _____ **Date:** _____

Why are you here to see the doctor today? Briefly describe your pulmonary (lung) problem. Tell when and how it began.

_____
_____
_____

Have you ever had any pulmonary (lung) problems as a child (asthma, wheezing, shortness of breath, recurrent lung infections)? If yes, please list the problems.

_____
_____

Respiratory symptoms:
Shortness of breath:

When do you have shortness of breath?

☐ ***On exertion*** ☐ ***At rest*** ☐ ***Both***

How long has this been going on (***days, weeks, months or years***)? _____

If your shortness of breath happens on exertion, approximately how far can you walk or how much activity can you do before you become short of breath? _____

_____

Does shortness of breath come on suddenly? ☐ **Yes** ☐ **No**

What, if anything, makes the shortness of breath **better** or **worse**?

Does it improve after coughing up thick sputum? ☐ **Yes** ☐ **No**

Is it improved after taking any particular medications? ☐ **Yes** ☐ **No**

If **Yes,** which medication _____

Is it worse in any particular position (i.e.: lying down, bending over)?

_____

Is it worse after eating? ☐ **Yes** ☐ **No**

Is it worse with exposure to ☐ ***dust*** ☐ ***fumes*** ☐ ***cold air*** ☐ ***other*** _____

_____

Is the shortness of breath associated with: **Check all that apply.**

☐ ***Drenching sweats***	☐ ***Blackouts***	☐ ***Chest pain***	☐ ***Fever***
☐ ***Swollen legs***	☐ ***ckouts***	☐ ***Nausea/vomiting***	
☐ ***Pounding heart***	☐ ***Chills***	☐ ***Wheezing***	

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Cough:

How long have you had trouble with coughing? _____

Has your cough changed recently? ☐ **Yes** ☐ **No**

** If **yes**, how has it changed? _____

Has your cough ever awakened you from sleep? ☐ **Yes** ☐ **No**

** If **yes**, how often does this occur? _____

Does your cough produce sputum? ☐ **Yes** ☐ **No**

****** If **yes**, what color? (Check one or more)

☐ ***Clear*** ☐***yellow*** ☐***white*** ☐***green*** ☐ ***tan*** ☐ ***brown*** ☐***red*** ☐**other** _____

How much sputum do you produce over ***24 hours***?

☐ ***Less than 2 tablespoons*** ☐ ***More than 2 tablespoons***

Have you ever coughed up blood? ☐ **Yes** ☐ **No**

** If ***yes***, when and how much? _____

What, if anything, makes your cough ☐ **better** or ☐ **worse** ?

Is it improved after taking any particular medications? ☐ **Yes** ☐ **No**

If ***yes*, which ones? _____

Is it worse in any particular position (i.e.: lying down, bending over)?

_____

Is it worse after eating? ☐ **Yes** ☐ **No**

Is it worse with exposure to ☐ **dust** ☐ **fumes** ☐ **cold air** ☐ other

_____

Chest Pain:

Where exactly is the chest pain located (ie: front, back, left, right)? _____

When do you have chest pain?

☐ ***On exertion*** ☐ ***At rest*** ☐ ***After meals***

How long does the pain last?

☐ ***Few seconds*** ☐ ***5 minutes*** ☐ ***15 minutes*** ☐ ***1 hour*** ☐ ***All day***

How long have you had chest pain?

☐ ***Less than a year*** ☐ ***1 to 3 years*** ☐ ***More than 3 years***

Is the pain increasing in frequency or intensity? ☐ **Yes** ☐ **No**

What, if anything, makes the pain go away? ☐ ***Resting*** ☐***Eating*** ☐ ***Medication (list):***

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Past chest x-rays:

Location	Reason	Date (month/year)

Review of symptoms:

If you have had any of the following symptoms **recently**, please check all that apply:

General:

☐ fevers chills night sweats (enough to soak your shirt or sheets)
☐ weight loss/gain (how much? _____ In what amount of time? _____)

Head, eyes, ears, nose, throat:

☐ itchy/watery eyes hay fever
☐ postnasal drainage bleeding nose or gums
☐ sore throat hoarseness
☐ sinus congestion or drainage (color? _____)

Cardiovascular:

☐ shoulder or arm pain
☐ swelling in your legs
☐ shortness of breath when lying flat
☐ awakening at night short of breath

Pulmonary:

☐ Snoring ☐ insomnia ☐ daytime sleepiness ☐ legs twitches/discomfort

Gastrointestinal:

☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ heartburn
☐ reflux indigestion ☐ abdominal/stomach pain

Genitourinary:

☐ bloody urine ☐ painful urination ☐ trouble starting/stopping

Musculoskeletal:

☐ joint pain ☐ swelling muscle pain

Hematologic:

☐ easy bleeding ☐ bruising

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Lymphatic: swelling of lymph nodes (Check one or more)

☐ under jaw ☐ on neck ☐ under arms ☐ in groin

Skin: ☐ new rashes ☐ spots

Back: ☐ pain ☐ swelling

Neurological:

☐ headaches seizures ☐ passing out ☐ numbness/tingling in hands or feet

Past Medical History:

Please list any current or past medical illnesses and hospitalizations and the approximate dates:

_____

_____

_____

Please list all surgeries and approximate dates:

_____

_____

Medications (prescription and nonprescription)**:**

Name of medication	Dose	Times per day	Length of time used	Prescribing Physician

List **allergies** to:

Drugs: _____

Food: _____

Environment: _____

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Social History:

Smoking history:

How many packs per day? _____ How many years have you smoked? _____

Have you smoked pipes or cigars? ____ When did you quit smoking? _____

Exposure to secondhand smoke: ☐ never ☐ rarely ☐ occasionally ☐ often ☐ regularly

Number of alcoholic drinks per week: ____

Illicit drug use: ☐ marijuana ☐ cocaine ☐ narcotics ☐ Valium ☐ LSD ☐ IV drug use

Date of last flu shot: _____ Pneumovax: _____

Current occupation: _____

Previous occupations: _____

List any jobs, activities, or hobbies where you were routinely exposed to chemicals, powders, dusts, or other types of hazardous materials (i.e.: including asbestos, sandblasting and fumes)

Activity	Years of exposure	Type of hazardous exposure

Home environment in the last ten years. **Check** all that apply:

☐ Dog	☐ Livestock	☐ Old carpets	☐ Feather pillows
☐ Cat	☐ Horses	☐ Central air	☐ Indoor insect problem
☐ Bird	☐ Gas heat	☐ Old drapes	

Have you or anyone in your family had tuberculosis or a positive PPD skin test? ☐ **Yes** ☐ **No**
If **yes**, when and what treatment was given? _____

Please list any travel in the last 20 years

Outside of local region	Foreign
_____	_____
_____	_____
_____	_____

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Family History (include siblings, children and grandchildren; also make particular note of any diabetes, heart disease, strokes, hypertension, cancer, and asthma):

Family member	**Age**	**Medical Problem**	**Or**	**Age**	**Cause of Death**
Father					
Mother					
(Siblings)					
(Children)					

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Cancellation Policy

In order to maintain a healthy Doctor-patient relationship and provide you with the very best care possible, it is our office policy that we require a **48 hours** notice when cancelling or rescheduling appointment.

If less than 48 hours is given or you fail to make it to your scheduled appointment there will be a $25 charge to your account.

We do understand that things come up, however we ask for a courtesy call to let us know that you would like to reschedule or cancel your appointment.

Patient Name: _____

Signed: _____ Date: _____

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TARRANT PULMONARY ASSOCIATES

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Tarrant Pulmonary Associates, must have my consent, therefore I authorize Tarrant Pulmonary Associates to disclose my PHI as described in the provided forms to the recipients listed below:

Description of the information to be disclosed (check all that apply):

☐ All Procedures ☐ Test Results ☐ Appointments ☐ Other ☐ Surgeries ☐ Billing/Account information

Name(s) of the person(s) authorized to obtain the above-mentioned information (e.g. family members and other specified person(s), physician other than your referring doctor).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Contact Information:
I authorize Texas Pulmonary & Critical Care Consultants, PA to contact me at the following number with results or questions:
Home_____ Cell_____ Work_____

May we leave a detailed message on your answering machine or voicemail?

☐ **Yes** ☐ **No** ** Failure to check one of these boxes may delay results.

By Patient: (printed name) _____ DOB: _____

Patient Signature: _____ Date: _____

Or Patient's Representative (print name, sign and describe authority)
_____ Date: _____

By signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. You understand that your records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that you have the right to revoke this authorization at any time, provided you do so in writing; that you have been given the opportunity to ask questions; that you have received a copy of the signed authorization; that you may inspect a copy of your PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to you or your treatment upon receipt of this signed authorization; and that you may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

TARRANT PULMONARY ASSOCIATES

Authorization To Release Health Care Information

Patient Name _____ SSN _____ DOB _____

Patient Address _____

I request and authorize _____
Name of Clinic/Practice

to release the medical records of the patient named above to:

Tarrant Pulmonary Associates
3602 Matlock Rd, Suite 206
Arlington, TX 76015
Fax# 888-720-1899

This request and authorization apply to:

☐ Health care information related to the following treatment, condition, or dates of treatment:

_____

☐ All health care information including Medication and Radiology

☐ Other

Purpose of disclosure:

I understand that my express consent is required to release any health care information relating to testing diagnosis, and/or psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, sexually transmitted disease, psychiatric/ mental health disorders, drug and/or alcohol abuse you must be specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signed: _____ _____
Patient or Representative Date

_____ _____
Relationship to Patient Witness