PATIENT REGISTRATION

Please print and complete ALL blanks. Appointment Date _____

Please visit our website: www.tlclungandsleep.com

PATIENT INFORMATION	(Last) (First) (Middle) Name: _____ Address: _____ Home Phone: _____ City, ST, Zip: _____ Sex: _____ Age: _____ Marital Status: ❒ S ❒ M Date of Birth: _____ Race: _____ Ethnicity: _____ Language: _____ Email Address: _____ Social Security No.: _____ Employer's Name and Address: _____ Employer's Phone No. : _____ Occupation: _____
SPOUSE'S INFORMATION	Spouse's Name: _____ IF YOU ARE COVERED UNDER YOUR SPOUSE'S INSURANCE PLEASE COMPLETE: Spouse's Date of Birth: _____ Spouse's Social Security No.: _____
OUT OF STATE ADDRESS (IF APPLICABLE)	Address: _____ City, ST, Zip: _____ Home Phone: _____
FRIEND OR RELATIVE NOT LIVING WITH YOU	Name: _____ Relationship: _____ Address: _____ Phone No.: _____
REFERRED BY:	Name: _____
INSURANCE INFORMATION	Do you have Medicare? Y N Medicare # _____ If not, what is your insurance? _____ Insured's Name: _____ Relationship to patient: _____ Address of Company: _____ Policy No.: _____ Group No.: _____ Do you have other insurance? _____ Insured's Name: _____ Relationship to patient: _____ Address of Company: _____ Policy No.: _____ Group No.: _____

PLEASE GIVE THE SECRETARY YOUR INSURANCE CARDS SO SHE CAN SCAN IT TO YOUR FILE.

ASSIGNMENT OF BENEFITS: (Allows us to file for your insurance) I hereby assign all medical, to include major medical benefits to which I am entitled including Medicare and private insurance and any other health plans to: The Lung Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize The Lung Center to download my medication history and Rx benefits into my account from a Rx clearinghouse.

SIGNED: _____ DATE: _____

PLEASE FILL OUT BOTH SIDES !

LIST ANY SURGERIES: _____

_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? (If so, place a check (✓) by it.)

( ) Headaches
( ) Earaches
( ) Sore throat
( ) Sinus trouble
( ) Hoarseness
( ) Eye problems
( ) Chest pain or pressure
( ) Short of breath
( ) Sleep on more than one pillow
( ) Ankles swelling
( ) Rapid heartbeat
( ) Heart skipping beats
( ) Cough

( ) Abdominal pain
( ) Nausea
( ) Vomiting
( ) Trouble swallowing
( ) Constipation
( ) Diarrhea
( ) Blood in stools
( ) Black stools
( ) Weight gain
( ) Weight loss
( ) Yellow skin
( ) Urine burns
( ) Blood in urine

( ) Cloudy urine
( ) Frequent urination
( ) Urinating at night
( ) Hard to start stream
( ) Involuntary loss of urine
( ) Abnormal periods
( ) Vaginal discharge
( ) Excessive thirst
( ) Excessive urination
( ) Excessive appetite
( ) Double vision
( ) Trouble walking
( ) Trouble talking

( ) Numbness anywhere
( ) Weakness
( ) Dizzy spell
( ) Blackouts
( ) Pain in joints
( ) Back pain
( ) Muscle aches
( ) Easy bruising
( ) Prolonged bleeding
( ) Skin rash
( ) Breast lump

YOUR PAST HISTORY - PLEASE CHECK (✓) IF YOU HAVE EVER HAD ANY OF THE FOLLOWING BEFORE.

( ) Heart rhythm problem
( ) Heart attack
( ) Heart failure
( ) Angina
( ) High blood pressure
( ) Rheumatic fever
( ) Blood clots in legs or lungs
( ) Gout

( ) Tuberculosis
( ) Bronchitis
( ) Emphysema
( ) Asthma
( ) Anemia
( ) Ulcer
( ) Hepatitis
( ) Broken bones

( ) Glaucoma
( ) Pancreatitis
( ) Cancer
( ) Gallbladder trouble
( ) Colitis
( ) Urine infection
( ) Kidney stones
( ) Breast lumps

( ) Kidney trouble
( ) Prostate trouble
( ) Epilepsy
( ) Stroke
( ) Thyroid disease
( ) Diabetes
( ) Arthritis
( ) Trouble with periods
( ) Diverticulosis

What medicines are you now taking? Please include dose and frequency.
If you have a list, please hand it to the receptionist.

_____

_____

_____

_____

_____

What drug and environmental **ALLERGIES** do you have? _____

_____

_____

Have you ever smoked tobacco?
YES _____ How long?_____ How much?_____ When stopped?_____
NO _____
Do you drink alcoholic beverages?_____ How much per day?_____

FAMILY HISTORY - PLEASE INDICATE RELATIONSHIP
Does any direct relative (parents, children, etc.) have or has had:

( ) Asthma
( ) Emphysema
( ) Heart problems at age under 60
( ) Hay Fever
( ) Lung Cancer
( ) Allergies
( ) Diabetes
( ) TB
( ) High Blood Pressure

I certify that the above information is correct to the best of my knowledge.

Signed_____ Date_____