NORTH TEXAS PULMONARY CRITICAL CARE
Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM ____/DD ____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ____-____-____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM ____/DD ____/YYYY _____

Social Security Number ____-____-____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY ____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY ____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

NORTH TEXAS PULMONARY CRITICAL CARE
MEDICAL QUESTIONNAIRE
Please complete all paperwork

LAST NAME_____ FIRST NAME_____MIDDLE NAME_____
BIRTHDATE_____ AGE_____GENDER: MALE OR FEMALE

PHARMACY INFORMATION

Name	
Phone	
Address	

ALLERGIES
PLEASE LIST ALL FOOD AND DRUG ALLERGIES AND THE TYPE OF REACTION

Drug	**Reaction**

MEDICATION LIST
PLEASE LIST ALL MEDICATION AND INHALERS

MEDICATION	**DOSAGE**	**FREQUENCY**	**ROUTE**

PULMONARY HISTORY

PLEASE CIRCLE IF YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- ☐ ALPHA-1 ANTITRYPSIN DEFICIENCY
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ COPD
- ☐ COUGH
- ☐ EMPHYSEMA
- ☐ INFLUENZA
- ☐ LUNG CANCER
- ☐ PLEURISY
- ☐ PNEUMONIA
- ☐ PULMONARY EMBOLISM
- ☐ PULMONARY FIBROSIS
- ☐ PULMONARY HYPERTENSION
- ☐ PULMONARY NODULE
- ☐ SHORTNESS OF BREATH
- ☐ SINUSITIS
- ☐ SLEEP APNEA WITH CPAP
- ☐ TUBERCULOSIS
- ☐ WHEEZING
- ☐ OTHER: _____

MEDICAL HISTORY

PLEASE CIRCLE IF YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- ☐ AIDS
- ☐ ALCOHOL ABUSE
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ BLOOD CLOTS
- ☐ BLOOD TRANSFUSION (YR: ____)
- ☐ BULEMIA
- ☐ CANCER TYPE: _____
- ☐ CATARACTS
- ☐ CHLAMYDIA
- ☐ CONGESTIVE HEART FAILURE
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ EASY BLEEDING
- ☐ ECZEMA
- ☐ EPILEPSY
- ☐ GENITAL HERPES
- ☐ GENITAL WARTS
- ☐ GLAUCOMA
- ☐ GONORRHEA
- ☐ GOUT
- ☐ HAY FEVER
- ☐ HEADACHES
- ☐ HEARING LOSS
- ☐ HEART ATTACK
- ☐ HEART MURMUR
- ☐ HEMORRHOIDS
- ☐ HEPATITIS A, B, C
- ☐ HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV
- ☐ HOT FLASHES
- ☐ HPV
- ☐ HYPERTHYORIDISM
- ☐ HYPOTHYROIDISM
- ☐ INFERTILITY
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MOTOR VECHICLE ACCIDENT
- ☐ SEIZURES
- ☐ SICKLE CELL ANEMIA
- ☐ SKIN DISEASE
- ☐ STROKE
- ☐ ULCERS
- ☐ OTHER: _____

SURGERY/PROCEDURE HISTORY
PLEASE CIRCLE ALL THAT APPLY AND INDICATE YEAR IF APPLICABLE.

☐APPENDIX REMOVED _____
☐BACK SURGERY _____
☐CARDIAC BYPASS _____
☐CATARACT SURGERY _____
☐COLONOSCOPY _____
☐ECHOCARDIOGRAM _____
☐ENDOSCOPY _____
☐FOOT SURGERY _____
☐GALLBLADDER REMOVED _____
☐HAND SURGERY _____
☐HERNIA REPAIR _____
☐HIP SURGERY _____
☐KNEE SURGERY _____
☐LUNG SURGERY _____
☐MAMMOGRAM _____
☐MASECTOMY _____
☐NEPHRECTOMY (KIDNEY REMOVED) _____
☐OTHER: _____ _____
☐PARTIAL COLECTOMY (COLON) _____
☐SHOULDER SURGERY _____
☐SMALL BOWEL RESECTION _____
☐SPLENECTOMY (SPLEEN) _____
☐STENT PLACEMENT _____
☐STRESS TEST _____
☐THYROID REMOVED _____
☐TONSILS REMOVED _____
☐VALVE REPLACEMENT _____

HOSPITALIZATION HISTORY
PLEASE LIST ANY CONDITION REQUIRING HOSPITALIZATION

REASON FOR HOSPITALIZATION	**YEAR**

FAMILY HISTORY

RELATIVE	**AGE**	**IF DECEASED, AGE AT DEATH**	**MEDICAL CONDITIONS/CAUSE OF DEATH**
MOTHER			
FATHER			
MATERNAL GRANDMA			
MATERNAL GRANDPA			
PATERNAL GRANDMA			
PATERNAL GRANDPA			
SIBLINGS			
CHILDREN			

SOCIAL HISTORY

PLEASE CHECK ONE OF THE FOLLOWING BELOW AND FILL IN THE BLANK.

DO YOU USE TOBACCO PRODUCTS?

☐ 1. NO, I HAVE NEVER USED TOBACCO PRODUCTS.

☐ 2. FORMER SMOKER, I DO NOT SMOKE CIGARETTES NOW. I STARTED SMOKING AT AGE ☐. I QUIT SMOKING AT AGE ☐. IN THE PAST I SMOKED AT MOST ☐ PACKS PER DAY.

☐ 3. CURRENT EVERYDAY SMOKER. I STARTED SMOKING AT AGE ☐. ON AVERAGE I SMOKE ☐ PACKS PER DAY.

PLEASE CIRCLE YES OR NO. IF YES, PLEASE SPECIFY.

DO YOU REGULARLY DRINK ALCOHOL?	YES OR NO ☐ ☐	IF YES, WHAT AMOUNT?
DO YOU DRINK CAFFEINE?	YES OR NO ☐ ☐	IF YES, HOW MANY CUPS PER DAY?
HAVE YOU EVER USED STREET DRUGS?	YES OR NO ☐ ☐	IF YES, WHAT TYPE?
ARE YOU CURRENTLY USING STREET DRUGS?	YES OR NO ☐ ☐	IF YES, WHAT TYPE?

VACCINATION HISTORY

DATE OF LAST PNEUMONIA VACCINE?	
DATE OF LAST TETNUS BOOSTER?	
DATE OF LAST INFLUENZA VACCINE?	

HAVE YOU HAD A TUBERCULOSIS SKIN TEST? YES OR NO _____

IF YES, WAS IT POSITIVE OR NEGATIVE? _____

DID YOU HAVE A CHEST X-RAY AFTER THE TUBERCULOSIS SKIN TEST? YES OR NO _____

IF YES, WERE THE RESULTS NORMAL? YES OR NO ☐

NORTH TEXAS PULMONARY CRITICAL CARE

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

North Texas Pulmonary Critical Care

PATIENT NAME_____DATE OF BIRTH_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. **_____(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **NORTH TEXAS PULMONARY CRITICAL CARE** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **_____(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **NORTH TEXAS PULMONARY CRITICAL CARE** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **NORTH TEXAS PULMONARY CRITICAL CARE** any insurance or other third-party benefits available for health care services provided to me. I understand **NORTH TEXAS PULMONARY CRITICAL CARE** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **NORTH TEXAS PULMONARY CRITICAL CARE,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **NORTH TEXAS PULMONARY CRITICAL CARE** by the Medicare or Medicaid program.

5. **_____(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **NORTH TEXAS PULMONARY CRITICAL CARE**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **NORTH TEXAS PULMONARY CRITICAL CARE** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **NORTH TEXAS PULMONARY CRITICAL CARE** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **_____(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Guarantor
- ☐ Healthcare Power of Attorney
- ☐ Other (please specify)_____

NORTH TEXAS PULMONARY CRITICAL CARE - PATIENT CONTROLLED SUBSTANCE AGREEMENT

Controlled substances are drugs we prescribe to reduce, but not cure your pain. As doctors, we want to provide the best care for your problem; however, because of the concerns we have when we prescribe controlled substances, we feel it is necessary to notify you of our expectations.

When taking controlled substances, it is important to understand that the medications can lose their effectiveness if not taken as prescribed. Side effects may occur, including constipation, drowsiness and sedation. If this occurs, please notify us. It is also important for you to know that, in rare cases, psychological addiction may occur. We do not want psychological addiction to be a problem for our patients; if this occurs, your controlled substance prescription may be stopped. As doctors, we are under strict regulation by the law, and have guidelines we must follow in prescribing all drugs.

Rules of this Controlled Substance contract are for your comfort and to yield maximum benefit:

1. You agree that if you lose your controlled substances or prescriptions for any reason, you will not get a replacement prescription for your controlled substance.
2. You agree that your prescriptions will be given to you on your appointment day only; do not call the clinic for controlled substance medications.
3. You agree to use only one pharmacy to fill your controlled substance prescriptions.
4. You agree to show up for all your appointments here, and provide notification at least 24 hours in advance if you are unable to come to your appointment.
5. You agree that you will take the controlled substance medications exactly as prescribed and will not take more pills in one day than allowed.
6. You agree that you will obtain controlled substances only from this office. If you have an injury or develop a new pain problem between your clinic visits here (i.e. go to the Emergency Room etc.), and receive controlled substance medications you agree to notify us immediately of the medicine, the dosage, and the number of pills given.
7. You agree that you will not sell or share your controlled substances.
8. You agree to notify this office immediately if you become pregnant.
9. You agree that a drug screen may be performed from time to time without notice.
10. You agree that if any of these rules are broken, controlled substance therapy may stop.
11. You agree that if your doctor gives you a referral to see a Pain Specialist, it is your responsibility to make an appointment with that doctor/group. The Pain Specialist will manage your pain medications form that point forward. After the referral has been completed, we will not refill your pain medications in this office.
12. You agree as a part of your treatment plan to see a specialist as referred. This may include Orthopedist, Physical Medicine specialist, and or Psychiatrist. Non-compliance with these referrals can result in your dismissal from this practice.

You have read and understand all the above expectations and agree to be held to the terms in full. If these terms are not upheld, the physician may decide with proper notice to stop treating you completely.

Patient's Signature_____ Date_____

Physician's Signature_____ Date_____