

NORTH TEXAS PULMONARY CRITICAL CARE  
Patient Registration Form (eCW)

(Please Print)

**PATIENT INFORMATION**

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** \_\_\_\_\_



**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  
HYPERTHYROIDISM  
HYPOTHYROIDISM  
INFERTILITY  
KIDNEY DISEASE  
LIVER DISEASE  
MOTOR VEHICLE 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 from 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 \_\_\_\_\_