



Welcome, AND thank you for choosing our practice! Included below is information to help you prepare for your visit.

For **every** appointment with our office, please check in **20 minutes prior** to your scheduled appointment time. This will allow us to ensure we have all the necessary information for each visit with your provider.

Tax ID: 86-0220398  
Hours: 8am – 5pm  
Phone: 602-258-4951  
Central Sched: 602-346-4771

PULMONARY DISEASE  
CRITICAL CARE MEDICINE  
SLEEP DISORDERS MEDICINE  
PULMONARY HYPERTENSION  
INTERVENTIONAL BRONCHOSCOPY  
ADULT CYSTIC FIBROSIS  
CLINICAL RESEARCH

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In an effort to provide you with the best possible care, our office will require;

### **First Appointment** –

- ✓ Picture ID
- ✓ Insurance cards
- ✓ Pharmacy Information (Name and Phone number)
- ✓ If your insurance requires a copay, please be prepared to pay at the time of your visit.
- ✓ Completed New Patient Packet (Attached)
- ✓ Medication List (Attached)
- ✓ Copies of your most recent chest imaging (Chest X Ray, CT Chest, PET Scan, etc.)  
\*Please obtain the disk/film to bring to your appointment\*
- ✓ Any pertinent Medical records that will assist in your visit
- ✓ If you are scheduled for a breathing related concern, please refrain from using a rescue inhaler/nebulizer 2 hours prior to appointment time as we may perform a Spirometry breathing test

### **Every Follow Up Appointment** –

- ✓ Completed brief questionnaire (Provided upon check-in)
- ✓ Copy of current medication list
- ✓ If your insurance requires a copay, please be prepared to pay at the time of your visit.
- ✓ Copies of your most recent chest imaging (Chest X Ray, CT Chest, PET Scan, etc.)  
\*Please obtain the disk/film to bring to your appointment\*
- ✓ If you are also scheduled for a Spirometry breathing test, please refrain from using a rescue inhaler/nebulizer 2 hours prior to appointment time

If you have been treated for a pulmonary/respiratory condition at Urgent Care, ER or been hospitalized since your last appointment, please notify our office so we may obtain the records for your appointment.

### **Full Pulmonary Function Test** –

- ✓ Copy of current medication list
- ✓ Refrain from using a rescue inhaler/nebulizer 4 hours prior to appointment time
- ✓ Refrain from smoking 1-hour prior to appointment

Thank you for the opportunity to be a part of your health care team!

Pulmonary Associates, PA



# PULMONARY ASSOCIATES, PA

## New Patient Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Why are you seeing a pulmonary (lung) provider? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you recently been hospitalized: Yes No When: \_\_\_\_\_ month/year Where: \_\_\_\_\_

Have you recently been in Urgent Care: Yes No When: \_\_\_\_\_ month/year Where: \_\_\_\_\_

Have you recently had any of the following:

- Chest X Ray When: \_\_\_\_\_ month/year Where: \_\_\_\_\_
- Chest CT (cat scan) When: \_\_\_\_\_ month/year Where: \_\_\_\_\_
- Echocardiogram When: \_\_\_\_\_ month/year Where: \_\_\_\_\_

Have you had exposure to chemicals: Yes No Type: \_\_\_\_\_

Have you recently traveled outside of the country: Yes No Where: \_\_\_\_\_

Have you had Flu Vaccine(s): Yes No I do not wish to have vaccines

Please list the last 2: \_\_\_\_\_ month/year, \_\_\_\_\_ month/year

Have you had Pneumonia Vaccine(s): Yes No I do not wish to have vaccines

Which one and when: Prevnar 13 \_\_\_\_\_ date, Pneumovax \_\_\_\_\_ date

## REVIEW OF SYMPTOMS

Please check any symptoms you are CURRENTLY experiencing below:

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### GENERAL

- NONE
- Fatigue (easily tired)
- Malaise (generally unwell)
- Fevers
- Chills
- Night Sweats
- Recent Weight Loss
- Recent Weight Gain

### ENT

- NONE
- Earache
- Hoarseness
- Nasal Congestion
- Post Nasal Drainage
- Sinus Pressure
- Sore Throat

### RESPIRATORY

- NONE
- Cough
- Shortness of Breath
- Coughing up Blood
- Pain with Breathing
- Wheezing
- Known TB Exposure

### CARDIOVASCULAR

- NONE
- Chest Pain
- Claudication (leg pain with activity)
- Edema (lower leg swelling)
- Palpitations
- Orthopnea (shortness of breath when lying down)

### GASTROINTESTINAL

- NONE
- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Nausea
- Vomiting

### GENITOURINARY

- NONE
- Increase in Urination
- Urination During the Night

### PSYCHOLOGICAL

- NONE
- Anxiety
- Depression

### DERMATOLOGIC

- NONE
- Hives
- Rash
- Itching
- Skin Lesions

### NEUROLOGICAL

- NONE
- Dizziness
- Numbness in Hands/Feet
- Weakness in One/Both Arms/Legs
- Abnormal Gait (unusual walking)
- Headache
- Memory Loss
- Seizures
- Tremors

### MUSCULOSKELETAL

- NONE
- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Weakness

### HEMATOLOGIC/LYMPHATIC

- NONE
- Easy Bleeding
- Easy Bruising
- Swollen Lymph nodes/glands

### IMMUNOLOGIC

- NONE
- Seasonal Allergies
- Contact Allergies
- Food Allergies
- Inhalation Allergies

### SLEEP

- NONE
- Insomnia
- Wake with Gasping/Choking
- Sleepiness During the Daytime
- Restless Sleep
- Snoring

## PERSONAL MEDICAL HISTORY

### PULMONARY

- Allergies
- Alpha 1 Antitrypsin
- Asbestosis
- Asthma
- Recurrent Bronchitis
- COPD
- Emphysema
- Lung Nodule(s)
- Pneumonia
- Pulmonary Embolism
- Pulmonary Fibrosis
- Sarcoidosis
- Sleep Apnea
- Valley Fever (Coccidioidomycosis)

### RHEUMATOLOGIC

- Lupus
- Rheumatoid Arthritis

### CARDIOVASCULAR

- Anemia
- Atrial Fibrillation
- Blood Clots/DVT
- Chest Pain (Angina)
- Congestive Heart Failure
- Coronary Artery Disease
- Elevated Cholesterol
- High Blood Pressure (HTN)
- Heart Attack (MI)
- Murmur/Heart Valve Disease
- Stroke

### GASTROINTESTINAL

- Acid Reflux (GERD)
- Hepatitis, Type: C B A

### GENITOURINARY

- Kidney Stones
- Chronic Kidney Disease

### NEUROLOGIC/PSYCHOLOGICAL

- Anxiety
- Bipolar Disorder
- Dementia
- Depression
- Insomnia
- Restless Leg Syndrome

### METABOLIC

- Diabetes, Type: 1 2
- Hyperthyroidism
- Hypothyroidism

### MUSCULOSKELETAL

- Fibromyalgia
- Osteoarthritis

### OTHER

- Cancer, Type: \_\_\_\_\_
- HIV/AIDS
- Tuberculosis
- Immunoglobulin Deficiency

Additional Medical History \_\_\_\_\_

## SURGICAL HISTORY

### PULMONARY

- |   |       |
|---|-------|
| <input type="checkbox"/> Bronchoscopy   | _____ |
| <input type="checkbox"/> Lobectomy: L R | _____ |
| <input type="checkbox"/> Lung Biopsy    | _____ |
| <input type="checkbox"/> Lung Surgery   | _____ |
| <input type="checkbox"/> Tonsillectomy  | _____ |
| <input type="checkbox"/> Adenoidectomy  | _____ |
| <input type="checkbox"/> Tracheostomy   | _____ |
| <input type="checkbox"/> Sinus Surgery  | _____ |

### CARDIOVASCULAR

- |  |       |
|--|-------|
| <input type="checkbox"/> CABG/Open Heart Surgery | _____ |
| <input type="checkbox"/> Cardiac Catheterization | _____ |
| <input type="checkbox"/> Cardiac Stent           | _____ |
| <input type="checkbox"/> Pacemaker               | _____ |

### GASTROINTESTINAL

- |   |       |
|---|-------|
| <input type="checkbox"/> Appendix Removal     | _____ |
| <input type="checkbox"/> Gall Bladder Removal | _____ |
| <input type="checkbox"/> Gastric Bypass       | _____ |
| <input type="checkbox"/> Hernia Repair        | _____ |

### GENITOURINARY

- |   |       |
|---|-------|
| <input type="checkbox"/> Dialysis             | _____ |
| <input type="checkbox"/> Kidney Stone Removal | _____ |
| <input type="checkbox"/> Kidney Removal       | _____ |

### MUSKULOSKELETAL

- |   |       |
|---|-------|
| <input type="checkbox"/> Back Surgery             | _____ |
| <input type="checkbox"/> Hip Replacement: L R     | _____ |
| <input type="checkbox"/> Knee Replacement: L R    | _____ |
| <input type="checkbox"/> Neck Surgery             | _____ |
| <input type="checkbox"/> Rotator Cuff Repair: L R | _____ |

### FEMALE

- |   |       |
|---|-------|
| <input type="checkbox"/> C-Section (Cesarean) | _____ |
| <input type="checkbox"/> Hysterectomy         | _____ |
| <input type="checkbox"/> Tubal Ligation       | _____ |

### MALE

- |   |       |
|---|-------|
| <input type="checkbox"/> Prostate Surgery | _____ |
|---|-------|

### OTHER

- |  |       |
|--|-------|
| <input type="checkbox"/> Cataract Surgery  | _____ |
| <input type="checkbox"/> LASIK             | _____ |
| <input type="checkbox"/> Lymph Node Biopsy | _____ |
| <input type="checkbox"/> Mastectomy        | _____ |
| <input type="checkbox"/> Thyroidectomy     | _____ |

Additional Surgical History \_\_\_\_\_

## FAMILY HISTORY

No Significant Family History

Adopted

### PULMONARY

Alpha 1 Antitrypsin	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Asthma	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
COPD	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Emphysema	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Pulmonary Fibrosis	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Pulmonary Hypertension	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Sarcoidosis	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Sleep Apnea	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### CANCER

Breast Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Colon Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Lung Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Other Cancer _____	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### CARDIOVASCULAR

Coronary Artery Disease	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Hypertension	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Venous Thrombosis	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### RHEUMATOLOGIC

Rheumatoid Arthritis	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Lupus	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### NEUROLOGICAL

Alzheimer's	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Dementia	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

### ENDOCRINE

Diabetes	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
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### SOCIAL

Alcoholism	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Drug Abuse	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

Additional Family History \_\_\_\_\_

## SOCIAL HISTORY

**Do you use Tobacco:** Yes No Former **Type of Tobacco:** Cigarettes Cigar Pipe Chew Smokeless  
**Overall Daily Average:** \_\_\_\_\_ pack(s)/pipe/can **Total # of Years Used:** \_\_\_\_\_ **Date Quit:** \_\_\_\_\_

**Do you drink Alcohol:** Yes No Former **Type of alcohol:** Beer Wine Liquor **How Much:** \_\_\_\_\_ Beers/Glasses/Drinks  
**Date Quit:** \_\_\_\_\_ **How Often:** Daily Weekly Monthly Yearly

**Do you drink Caffeine:** Yes No **Type of Caffeine:** Coffee Tea Soda Energy drinks **How Much:** \_\_\_\_\_ cups/ounces

**Do you use Recreational drugs:** Yes No Former **Type:** \_\_\_\_\_ **How Often:** Daily Weekly Yearly **Date Quit:** \_\_\_\_\_

**Do you Exercise:** Yes No **Type of Exercise:** \_\_\_\_\_ **How Much:** \_\_\_\_\_ **How Often:** Daily Weekly Monthly

**Occupation:** \_\_\_\_\_ **Marital Status:** Single Married Life Partner Divorced Widowed  
**# of Years in Arizona** \_\_\_\_\_ **Domestic Partner:** Opposite Sex Same Sex  
**# of Children:** \_\_\_\_\_ Sons \_\_\_\_\_ Daughters **Pets:** Yes No **Type:** \_\_\_\_\_





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Tel. 602.258.4951

9225 N. 3rd Street  
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Phoenix, AZ 85020  
Tel. 602.258.4951

5750 W. Thunderbird Road  
Building E500  
Glendale, AZ 85306  
Tel. 602.258.4951

5151 E. Broadway Road  
Suite #107  
Mesa, AZ 85206  
Tel. 602.258.4951

10585 N. Tatum Blvd  
Suite #D130  
ParadiseValley, AZ 85253  
Tel. 602.258.4951

1941 N. 27th Avenue  
Suite #102  
Phoenix, AZ 85027  
Tel. 602.258.4951

### Authorization to Release Information

The purpose of this form is for YOU (patient) to give Pulmonary Associates permission to release information regarding your care to the Family/Friend listed below. Please review, complete, sign & date and return to our front desk.

(Ex: prescription pick-up, appointment coordination, record retrieval, etc...)

**Patient Name:** \_\_\_\_\_ **Date Of Birth:** \_\_\_\_\_ **SSN #:** \_\_\_\_\_

I, \_\_\_\_\_, authorize Pulmonary Associates, PA to communicate with the person/persons listed below regarding my care and treatment.

1. _____	_____
<b>Name</b>	<b>Address</b>
Telephone #: (____) _____	_____ <b>85</b> _____
	<b>City/State</b> <b>Zip Code</b>
2. _____	_____
<b>Name</b>	<b>Address</b>
Telephone #: (____) _____	_____ <b>85</b> _____
	<b>City/State</b> <b>Zip Code</b>

\_\_\_ Verbal Communication

\_\_\_ Other (Please Specify): \_\_\_\_\_

#### The purpose of this release: COORDINATION OF CARE

Pulmonary Associates, PA is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time (in writing) with the exception that action has already been taken on the consent. Unless otherwise specified, this consent expires one year following date of signature.

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization of the release of medical or other information for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." I understand records or information in the records will not be covered under Federal Privacy Laws should the RECEIPT of my records re-disclose them. Note: A photocopy and/or facsimile of this consent shall be considered valid as original.

\_\_\_\_\_  
**Patient/Parent/Guardian Signature**

\_\_\_\_\_  
**Form to EXPIRE 1 year from original signed date**



## **Pulmonary Associates Office and Financial Policies:**

Thank you for choosing Pulmonary Associates, PA. for your medical needs. We are committed to providing you with the highest quality medical care and maintaining a good physician-patient relationship is our primary goal. Even when insurance is in place, patients are ultimately responsible for charges associated with their care. As your provider, we feel it is our responsibility to let you know in advance of our office and financial policies. This will allow for a good flow of communication and enable us to achieve our physician-patient relationship goal. We realize you have choices for your medical care, and we sincerely appreciate you choosing Pulmonary Associates, PA.

For our patient's convenience, we participate in most major health plans. Our business office will submit claims for services rendered and will assist you in any reasonable way in getting your claims paid. It is the patient's responsibility to provide all necessary information during the appointment scheduling process as well as ensuring there is an authorization and/or referral form from your PCP if it is required by your insurance.

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

### **FEES AND SURCHARGES**

- **\$25.00 Fee for No Shows and Late Cancellations (cancelling with less than 24-hrs notice):**  
To avoid this fee, please call (602) 258-4951 to cancel or reschedule all appointments within 24 hours of your scheduled appointments. If you are not able to get through or call after business hours, please leave a voicemail of your cancellation.
- **\$25.00 Fee for Form Completion:**  
There will be a fee of \$25.00 for all forms needing completion outside an office visit.
- **FEES for Processing Medical Records Request Forms:**

1-10 pages	= \$10.00
11-20 pages	= \$15.00
21+ pages	= \$25.00
- **Administrative Collection Fees:**  
Any outstanding balances sent to a third party collection agency will incur a 20% fee. In addition, you may not be able to make future appointments until this balance is discussed with our billing department.
- **\$10.00 Surcharge Fee:**  
Your insurance requires you to pay your co-payment at the time of service. Failure to pay in full at the time of service will result in a \$10.00 surcharge fee.
- **\$25.00 NSF Fee for Returned Checks:**  
All returned checks will incur an additional \$25.00 fee, and we will require alternative payment for all future visits.

Please **SIGN** and **DATE** below acknowledging your notification of these fees:

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_