

Pulmonary and Medical Associates of Northern Virginia, LTD.

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|--|---|--|
| <input type="checkbox"/> Steven M. Zimmet, M.D. | <input type="checkbox"/> Robert M. Kruger, M.D. | <input type="checkbox"/> Mary Margaret Lewis, M.D. |
| <input type="checkbox"/> Wilson L. Coudon, M.D. | <input type="checkbox"/> David R. Duhamel, M.D. | <input type="checkbox"/> Michael D. Jacobson, P.A.-C |
| <input type="checkbox"/> M. Anthony Casolaro, M.D. | <input type="checkbox"/> Jeff B. Hales, M.D. | <input type="checkbox"/> Lisa C. Moak, P.A.-C |
| <input type="checkbox"/> Lawrence M. Stein, M.D. | <input type="checkbox"/> Christopher C. Wyckoff, M.D. | <input type="checkbox"/> Kelley Brown, RRT |

- New Patient**
 Established Pt. / Update

PATIENT INFORMATION

DATE: _____

PATIENT'S SOCIAL SECURITY NUMBER _____

LAST NAME:		FIRST:		MI:	HOME PHONE: () ()
ADDRESS:					WORK PHONE: () ()
CITY:		STATE:	ZIP:	CELL PHONE: () ()	
DATE OF BIRTH: (Mo./Day/Yr.)			SEX(M/F): ____ EMPLOYED(Y/N): ____ STUDENT:(FT/PT) ____		FAX: () ()
EMPLOYER/SCHOOL NAME:			OCCUPATION:	E-MAIL:	
PERSON TO NOTIFY IN CASE OF EMERGENCY:			RELATIONSHIP TO PT.:		EMERGENCY PHONE NO: () ()
MARITAL STATUS: <i>Single / Married / Divorced / Widowed</i>	NAME OF SPOUSE:		SPOUSE DATE OF BIRTH	SPOUSE SOC. SEC. #	SPOUSES PHONE NO. () ()
RESPONSIBLE PARTY: (If other than Patient)		RELATIONSHIP TO PT.:		RESPONSIBLE PARTY SS #	RES. PARTY PHONE NO. () ()
BILLING ADDRESS: (If different from above)					
REFERRED BY OR REFERRING PHYSICIAN:				ACCIDENT DATE (IF APPLICABLE):	
ANY ALLERGIES:					PHARMACY PHONE NO. () ()

INSURANCE INFORMATION

PRIMARY INS. CARRIER			INSURANCE CARRIER PHONE NO.: () ()		
NAME OF POLICYHOLDER (If different than patient)		DATE OF BIRTH (Policy holder)		ID OR SOC. SEC. # OF POLICYHOLDER	
POLICY ID	GROUP #/NAME:	EFFECTIVE DATE:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF HUSBAND WIFE CHILD OTHER (Please circle appropriate answer).		
SECONDARY INS. CARRIER			INSURANCE CARRIER PHONE NO.: () ()		
NAME OF POLICYHOLDER (If different than patient)		DATE OF BIRTH (Policy holder)		ID OR SOC. SEC. # OF POLICYHOLDER	
POLICY ID	GROUP #/NAME:	EFFECTIVE DATE:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF HUSBAND WIFE CHILD OTHER (Please circle appropriate answer).		
PERSON TO BE BILLED AFTER INSURANCE IF OTHER THAN SELF?		SOCIAL SECURITY NUMBER		ADDRESS:	
WILL YOUR VISIT BE COVERED UNDER WORKMAN'S COMPENSATION OR OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, please complete below. If No, please continue to insurance authorization.					
EMPLOYER:			EMPLOYERS TELEPHONE NO. () ()		
SUPERVISOR'S NAME:		ACCIDENT DATE:		CASE NO.	

INSURANCE AUTHORIZATION

I hereby authorize Pulmonary and Medical Associates of Northern VA, Ltd. to apply for benefits on my behalf for covered services rendered me.

I request payment from Blue Cross/ Blue Shield of the National Capital Area, Medicare Part B or other insurance carrier be made directly to the provider of services.

I certify that the information I have reported with regard to my insurance is correct and authorize the release of medical information and other necessary information for this or any related claim to my insurance carrier or the above named billing agent(s) or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration.

I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked by me, the Blue Cross/Blue Shield of D.C., or the Social Security Administration at any time in writing.

Signature: _____ Date: _____

CONSENT FOR MINOR TO BE TREATED: _____ Relationship: _____

PLEASE SEE REVERSE SIDE

PULMONARY and MEDICAL ASSOCIATES of NORTHERN VIRGINIA, LTD.

PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Pulmonary and Medical Associates of Northern Virginia, Ltd. (hereafter PMANV) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (PMANV's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PMANV reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PMANV's Privacy Officer at 1400 South Joyce Street, #126, Arlington, Virginia 22202.

With this consent, PMANV may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, PMANV may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, PMANV may E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that PMANV restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to PMANV's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PMANV may decline to provide treatment to me.

I have reviewed a notice of privacy practices from Pulmonary and Medical Associates of NVA.

Signature of patient or legal guardian

Patient's name

Date

Printed name of patient or legal guardian

PULMONARY AND MEDICAL ASSOCIATES

Comprehensive Physical Evaluation

Name _____
Date of Appointment _____

Date of Birth _____
Place of Birth _____
Race _____
Primary language _____
Hispanic/Not Hispanic (circle one)

Please list the name of any other physicians/providers you see regularly:

Name _____

Past Medical History

Please list any medical problems that you have been diagnosed with:

Please list any surgeries and/or hospitalizations:

<u>Surgeries</u>	<u>Date</u>	<u>Hospitalizations</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Mother	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	Father	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
	Age: _____	Age at death: _____		Age: _____	Age at death: _____
Siblings (please specify)					
1. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	2. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
	Age: _____	Age at death: _____		Age: _____	Age at death: _____
3. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	4. _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
	Age: _____	Age at death: _____		Age: _____	Age at death: _____

Do any family members or relatives have the following disorders?

Please indicate mother, father, brother(s), sister(s). For grandparents, aunts and uncles, please indicate mother's or father's side.

Breast cancer _____
Colon cancer _____
Prostate cancer _____
Lung cancer _____
Skin cancer _____
Mental illness (please specify) _____
High blood pressure _____

Heart disease _____
Lung disease _____
Gastrointestinal disease _____
Kidney disease _____
Diabetes _____
Other illnesses _____

**** PLEASE FILL OUT BACK OF THIS SHEET AND SECOND SHEET ****

Patient Name _____

Review of Systems – Please check off the box of any symptom/illness you have or have had in the past.

General

- Fatigue
- Fever
- Night Sweats
- Trouble sleeping
- Unexplained weight change

Skin

- Change in wart/mole
- Skin cancer
- New lesions
- Rashes/Psoriasis/Hives

HEENT

- Decreased hearing
- Ringing in ears/Tinnitus
- Sinus trouble/nasal congestion
- Hay fever/allergies
- Hoarseness
- Frequent ear infections
- Ear perforation
- Recurrent nosebleeds
- Recurrent tonsillitis
- Glaucoma
- Eye infections

Respiratory

- Coughing up blood
- Chronic cough
- Shortness of breath
- Snoring
- Tuberculosis/Positive skin test
- Pneumonia
- Asthma
- COPD
- Bronchitis

Cardiovascular

- Chest pain
- Swollen ankles
- Leg pain/cramps
- Palpitations/Irregular pulse
- Heart murmur
- Varicose veins
-

Gastrointestinal

- Abdominal pain

- Change in bowel habit
- Nausea/vomiting
- Diarrhea
- Difficulty swallowing
- Hemorrhoids
- Indigestion/Heartburn
- Rectal bleeding
- Bloody or tarry stools
- Loss of appetite
- Constipation
- Colitis
- Diverticulosis
- Gall bladder problem
- Jaundice/hepatitis
- Hernia

Male Genitourinary

- Change in urinary stream
- Weak erections
- Urethral discharge
- Increased urinary frequency
- Pain with urination
- Testicular mass/pain
- Overnight urination
- Decrease in force of urination
- Problems with control of urination
- Blood in urine
- DES exposure
- Varicocele
- Prostate infection

Female Genitourinary

- Date of last menstrual period: _____
- Change in bladder habits
- Increased urinary frequency
- Urinary urgency
- Irregular periods
- Pain/bleeding after sex
- Vaginal discharge
- Severe pain w/periods
- Menopausal symptoms (hot flashes, etc.)
- Breast disease

Musculoskeletal

- Chronic back pain

- Joint pain _____ (which joint(s)?)
- Muscle weakness/pain
- Recent injuries?
- _____
- Arthritis/Rheumatism
- Gout

Neurologic

- Decreased memory
- Frequent headache
- Migraine headache
- Numbness/Tingling
- Weakness
- Seizures/convulsions
- Dizziness/fainting
- Double/blurred vision
- Stroke
- Tremor/shakiness

Psychiatric

- Anxiety
- Depression
- Moodiness
- Suicide attempt
- Mental illness
- Nervousness

Endocrine

- Cold intolerance
- Heat intolerance
- Change in appetite/thirst
- Diabetes
- Thyroid disease/Goiter

Hematologic

- Bruise easily
- Anemia
- Thrombophlebitis/ Blood clots
- Cancer _____ (type)

Allergy/Immunologic

- Food allergy
- Bee allergy
- Severe allergic response/Anaphylaxis

