



PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ MARITAL STATUS: \_\_\_ SINGLE \_\_\_ MARRIED \_\_\_ WIDOWED \_\_\_ DIVORCED

OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

WORK PHONE NUMBER: ( ) \_\_\_\_\_ SOCIAL SECURITY NO: \_\_\_\_\_

CELL PHONE NUMBER: ( ) \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

WORK PHONE NUMBER: ( ) \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ POLICYHOLDER NAME: \_\_\_\_\_

INSURANCE ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN #: \_\_\_\_\_

SECOND INSURANCE: \_\_\_\_\_ POLICYHOLDER NAME: \_\_\_\_\_

INSURANCE ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN #: \_\_\_\_\_

REF. / FAMILY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

PERSON TO CONTACT IN AN EMERGENCY: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **PULMONARY MEDICINE OF DAYTON, INC.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an 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 medical information to secure the payment.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_



**MEDICAL HISTORY**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Appointment Date \_\_\_\_\_

**Home #** \_\_\_\_\_ **Work #** \_\_\_\_\_

**Referring physician:** \_\_\_\_\_ **phone:** \_\_\_\_\_

**Family physician:** \_\_\_\_\_ **phone:** \_\_\_\_\_

**Other physicians:** \_\_\_\_\_ **phone:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **phone:** \_\_\_\_\_

*Why are you seeing the lung doctor (please describe your symptoms)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Abnormal Chest X-Ray/CatScan \_\_\_\_\_

**CURRENT PROBLEMS:**

Cough \_\_\_\_\_ How Long? \_\_\_\_\_

Clear / Green / Yellow (thick / thin / Sticky) \_\_\_\_\_

Coughing up blood \_\_\_\_\_ Amount (TSP / TBSP / Streaks) \_\_\_\_\_

Shortness of Breath (with or without activity) \_\_\_\_\_

Chest heaviness / Pressure / Tightness \_\_\_\_\_

Do you Snore (heavy / light) \_\_\_\_\_

Wheezing (all the time / with activity) \_\_\_\_\_

Weight Loss (how much / over how long) \_\_\_\_\_

Headaches \_\_\_\_\_

Nasal Drainage (clear/green/yellow) \_\_\_\_\_

Fevers \_\_\_\_\_

Hoarseness in voice \_\_\_\_\_

Trouble swallowing or Choking when eating or drinking \_\_\_\_\_

Other \_\_\_\_\_

**Do you have medication allergies: (list them)**

**Symptoms**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



MEDICAL HISTORY AND FAMILY HISTORY

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Appointment Date \_\_\_\_\_

Have you had the following done?

Breathing Test (when / where) \_\_\_\_\_ Chest x-ray (when) \_\_\_\_\_
CAT SCAN (when) \_\_\_\_\_ Cardiac Stress test (when) \_\_\_\_\_
Heart Catheterization (when) \_\_\_\_\_ 2-D Echocardiogram (when) \_\_\_\_\_
Pneumonia Vaccine (when): \_\_\_\_\_ Flu Vaccine (when) \_\_\_\_\_
Tuberculosis Exposure (when) \_\_\_\_\_ Last Skin test (positive / negative) \_\_\_\_\_

Past Medical Problems:

High Blood Pressure Pneumonia COPD / Emphysema
Heart Disease Asthma Diabetes
Cancer (when / where) \_\_\_\_\_ Other \_\_\_\_\_

Surgeries or Hospitalizations (Please List)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family History: Any health Problems?

Father: (Living / Deceased) \_\_\_\_\_
Mother: (Living / Deceased) \_\_\_\_\_
Brothers / Sisters: (Living / Deceased) \_\_\_\_\_
Children (Living / Deceased) \_\_\_\_\_

Habits: Do you do any of the following?

Smoke Cigarettes / Cigars How many a day \_\_\_\_\_ How many years \_\_\_\_\_ Quit When \_\_\_\_\_
Chew Tobacco \_\_\_\_\_ Use any other Drugs \_\_\_\_\_
Alcohol: Type / How much a day or week? \_\_\_\_\_

CURRENT MEDICATIONS: Please Print

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OCCUPATION / RETIRED / DISABLED: \_\_\_\_\_

Occupational Exposure:

(Asbestos, Chemicals, Fumes, Dust, Fibers, Metals, Radiation)
Coal Miner, Welder, Factory, Farmer, Grinder: \_\_\_\_\_
Pets: (inside / outside) / Any Birds? \_\_\_\_\_
Blood Transfusion (when / why) \_\_\_\_\_



The staff of Pulmonary Medicine of Dayton, Inc. will not directly use or allow the use of Pulmonary Medicine of Dayton data for any purpose other than that directly associated with any official assigned duties. We understand that all patient's information including financial data will be held strictly confidential. Official HIPAA manual is available for your review.

You have my permission to discuss my medical record information and account with the following individuals:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have received Pulmonary Medicine of Dayton, Inc.'s Notice of Privacy Practices.

Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_



**AUTHORIZATION TO DISCLOSE  
PROTECTED HEALTH INFORMATION**

Patient Name- \_\_\_\_\_

Date of Birth- \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Telephone #- (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Last 4 digits of SSN- \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release, use, and disclose health information about me as described below to the following individuals or entities:

Send To:

Send To:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

**RELEASE CONTENT**

Dates of Service Requested: \_\_\_\_\_

- COMPLETE MEDICAL RECORD
- PROGRESS NOTES
- HISTORY & PHYSICAL
- LAB/PATHOLOGY REPORTS
- EKG REPORTS
- PFT REPORTS
- DICTATED LETTERS
- ITEMIZED BILL
- RADIOLOGY REPORTS
- OTHER (PLEASE SPECIFY): \_\_\_\_\_

**REASON FOR DISCLOSURE**

My health information is being released or disclosed for the following reason(s)  
(check all that apply)

- PERSONAL
- LEGAL INVESTIGATION OR ACTION
- INSURANCE ELIGIBILITY OR BENEFITS
- CHANGING PHYSICIANS
- OTHER (PLEASE SPECIFY): \_\_\_\_\_

**CONSENT**

I understand that I may revoke authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

\_\_\_\_\_  
Signature of patient (or patient's personal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient representative

\_\_\_\_\_  
Representative's authority to sign for patient,  
(i.e. parent, guardian, power of attorney for healthcare, executor)