LINCOLN PULMONARY & CRITICAL CARE ASSOCIATES

PATIENT'S PERSONAL HISTORY **DATE ___/___/___**

NAME_____

ADDRESS_____

HOME PHONE_____ WORK _____ CELL _____

AGE _____ DOB ____/___/___ SEX M / F RACE _____ ETHNICITY _____

E-MAIL _____ SOCIAL SECURITY _____

PRIMARY CARE PHYSICIAN _____ OTHER SPECIALISTS _____

COUNTY _____ STUDENT Y / N PREFERRED LANGUAGE _____

WHO REFERRED YOU TO OUR CLINIC? _____

PAST MEDICAL HISTORY: PREVIOUS OPERATIONS

PROCEDURE	MONTH/YEAR	PROCEDURE	MONTH/YEAR

INFLUENZA VACCINE: _____ IF YES, PLEASE LIST YEAR(S) PNEUMOCOCCAL VACCINE: _____

DO YOU CURRENTLY HAVE, OR HAVE PREVIOUSLY HAD, ANY OF THE FOLLOWING? (CIRCLE THOSE THAT APPLY)

ARTHRITIS/RHEUMATOID/LUPUS	HIGH BLOOD PRESSURE	PULMONARY HYPERTENSION
CANCER	HEART DISEASE/ARRHYTHMIAS/STROKE	DIABETES
SHORTNESS OF BREATH/COUGH	HIGH CHOLESTEROL	SEIZURE DISORDER
ASTHMA/COPD	BLOOD CLOTS/ PULM. EMBOLI	LIVER DISEASE/HEPATITIS
BRONCHIECTASIS	KIDNEY DISEASE	ALLERGIC RHINITIS/SINUSITIS
CYSTIC FIBROSIS	ACID REFLUX/STOMACH ULCERS	TUBERCULOSIS/WHOOPING COUGH
PLEURISY	RESTLESS LEGS	DEPRESSION

ANY OTHER DISORDERS? _____

PRESENT MEDICATIONS: (PLEASE INCLUDE OVER-THE –COUNTER, VITAMINS,ETC.)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

PRESENT ALLERGIES & REACTIONS:

_____

_____

_____

SOCIAL HISTORY

MARITAL STATUS: (CIRCLE ONE) MARRIED DIVORCED SINGLE WIDOWED OTHER SIGNIFICANT RELATIONSHIP

OCCUPATION (CURRENT OR PRIOR): _____

EMERGENCY CONTACT: _____ PHONE: _____

POWER OF ATTORNEY'S NAME (IF APPLICABLE): _____

DO YOU HAVE AN ADVANCE DIRECTIVE, DNR, ETC? _____. IF YES, MAY WE PLEASE HAVE COPIES? _____

HABITS: TOBACCO USE: NEVER SMOKED _____ FORMER SMOKER _____ CURRENT SMOKER _____ CHEW/PIPE _____

IF EVER A TOBACCO USER, AVERAGE DAILY USE AND FOR HOW LONG: _____

TYPICAL NUMBER OF ALCOHOLIC DRINKS _____ PER DAY/WEEK/MONTH/YEAR (CIRCLE ONE)

ENVIRONMENTAL EXPOSURES (ASBESTOS, RADIATION, INHALED DUST, ETC) _____

FAMILY HISTORY: PLEASE LIST ANY BLOOD RELATIVES WHO HAVE OR HAVE HAD:

LUNG DISEASE _____ ASTHMA _____ HEART DISEASE _____

STROKE _____ SEIZURE DISORDER _____ DIABETES _____

HIGH BLOOD PRESSURE _____ KIDNEY DISEASE _____ SLEEP APNEA _____

I HAVE BEEN NOTIFIEED THAT A CLINICAL SUMMARY FROM THE OFFICE VISIT WILL BE AVAILABLE FOR ME TO PICK UP AT THE FRONT DESK, UPON REQUEST, WITHIN 1 BUSINESS DAYS.

_____ _____

(SIGNATURE) (DATE)

INSURANCE VERIFICATION INFORMATION

PATIENT NAME : _____ DOB: ___/___/___

INSURED'S NAME: _____ _ DOB: ___/___/___

RELATIONSHIP TO INSURED: _____

PRIMARY INSURANCE COMPANY: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ID # _____ GROUP # _____

NAME OF INSURED: _____ SSN: _____

SECONDARY INSURANCE COMPANY: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ID # _____ GROUP # _____

(PLEASE BRING YOUR INSURANCE AND PRESCRIPTION CARDS WITH YOU FOR EACH VISIT FOR COPIES AND VERIFICATION)

WE PARTICIPATE WITH MOST MAJOR INSURANCE COMPANIES, INCLUDING MEDICARE AND MEDICAID, AND WILL SUBMIT CLAIMS TO YOUR INSURER. PLEASE GIVE US ADVANCE NOTICE ABOUT ANY REQUIRED INSURANCE PRE-AUTHORIZATION. IF YOU HAVE MORE THAN ONE INSURANCE CARRIER OR IF YOUR HEALTH INSURANCE COVERAGE CHANGES, LET US KNOW AS SOON AS POSSIBLE SO THAT WE MAY PROCESS YOUR CLAIMS APPROPRIATELY. WE WILL BE HAPPY TO HELP YOU DEVELOP A PAYMENT PLAN IF NEEDED. CONTACT OUR BUSINESS OFFICE WITH ANY QUESTIONS. ALL FINANCIAL INFORMATION IS CONFIDENTIAL.

ASSIGNMENT OF INSURANCE BENEFITS:

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I, _____HERBY AUTHORIZE _____ TO PAY AND HERBY ASSIGN DIRECTLY
(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

TO **LINCOLN PULMONARY** ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED ON THE ATTACHED FORMS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I FURTHER ACKNOWEDGE THAT ANY INSURANCE BENEFITS, WHEN RECEIVED BY AND PAID TO **LINCOLN PULMONARY** WILL BE CREDITED TO MY ACCOUNT, IN ACCORDANCE WITH THE ABOVE SAID ASSIGNMENT.

_____ _____

(PATIENT SIGNATURE) (DATE)