# Patient Information

Please complete and submit these forms prior to your appointment. When you come please be sure to bring your insurance card and photo id. We look forward to seeing you!

Patient First Name Patient Middle Name Patient Last Name Date of Birth

Address Address 2 City State Zip

Sex Home Phone Cell Phone Martial Status

 Male  Female 

Other

Explain

 Single  Married

 Divorced  Widowed

 Separated  Partner  Legally Separated

Language

Race

Ethnic Group

Email

 English  Spanish

 Asian

 African American  Asian

 Decline to specify  White  Other **List**

 Central American

 Decline to specify  Hispanic or Latino

Emergency Contact First Name

Emergency Contact Last Name

Relationship Phone Number

Primary Insurance Co. ID Number Policy Holder Name DOB Relationship

Secondary Insurance Co.

ID Number Policy Holder Name DOB Relationship

# Authorization for Use and/or Disclosure of Information

Patient First Name Patient Middle Name Patient Last Name Date of Birth

I understand that:

1. Medical information is considered Protected Health Information (PHI) under both Federal and State Privacy Laws
2. This authorization will be valid as long as I am under the care of Austin Pulmonary Consultants
3. I may revoke this authorization at any time by notifying Austin Pulmonary Consultants
4. I authorize information to be released electronically (e.g fax)

Patient Signature

RECIPIENT (Person/Entity to Whom Information is to be sent)

Name of Provider Telephone Fax

North Office

3600W Parmer Ln Ste 106 Austin TX 78727

Information to be Disclosed:

 Demographic sheet  Most Recent Office Visit Note  Emergency Room Report  Laboratory Results 

Radiology Results  Sleep Study  PFT's  Entire Medical Record  Hospital/ER Records

Reason for Disclosure:

 Continuation of Care  Consultation

# Patient Medication and History

Patient First Name Patient Middle Name Patient Last Name Date of Birth

Peanut Allergy

 Yes  No  Not sure

Iodine Allergy

 Yes  No  Not sure

IV Contrast Allergy

 Yes  No  Not sure

Current Smoker

 Yes  No

How many packs per day How long have you smoked

Former Smoker

 Yes  No

How many packs per day

How many years did you smoke

Do you currently have Oxygen or a CPAP/BiPAP machine?

 Yes  No

If so who is the company that supplies that?

What year did you quit

# Medication Allergies and Reactions

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** |  | **Reaction** |  | **Medication Name** |  | **Reaction** |
| **Medication Name**  **Medication Name**  **Additional Medication** |  | **Reaction**  **Reaction** |  | **Medication Name**  **Medication Name** |  | **Reaction**  **Reaction** |
| + |  |  |  |  |  |  |
| **Medication Name** |  | **Reaction** |  | **Medication Name** |  | **Reaction** |
| **Medication Name** |  | **Reaction** |  | **Medication Name** |  | **Reaction** |
| **Medication Name** |  | **Reaction** |  | **Medication Name** |  | **Reaction** |
| **Medication Name** |  | **Reaction** |  | **Medication Name** |  | **Reaction** |
| Food Allergies and Reactions | | | | | | |
| **Food** |  | **Reaction** |  | **Food** |  | **Reaction** |
| **Food** |  | **Reaction** |  | **Food** |  | **Reaction** |
| **Additional Food Allergies** |  |  |  |  |  |  |

+

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Food** |  | **Reaction** |  | **Food** |  | **Reaction** |
| **Food** |  | **Reaction** |  | **Food** |  | **Reaction** |
| **Food** |  | **Reaction** |  | **Food** |  | **Reaction** |
| **Food** |  | **Reaction** |  | **Food** |  | **Reaction** |

# Current list of Medications

Medication Name Strength/Directions

Medication Name Strength/Directions

Medication Name Strength/Directions

Medication Name Strength/Directions

Medication Name Strength/Directions

Additional Medications

 +

Medication Name Strength/Directions

Medication Name Strength/Directions

Medication Name Strength/Directions

Medication Name Strength/Directions

Medication Name Strength/Directions

# Short Form

Patient First Name Patient Middle Name Patient Last Name Date of Birth

Pharmacy Name Street/Cross Street Pharmacy phone number

Pneumonia

 Pneumovax (PCV23)  Prevnar 13  Declines

N/A

Date PCV23

Pneumonia

  Pneumovax (PCV23)  Prevnar 13  Declines 

N/A

Date PCV23

Date Prevnar 13 Date Prevnar 13

Flu

 Yes  No  Declines

Date

Covid 1st dose

 Yes  No  Declines

Date

Covid 2nd dose

 Yes  No  Declines

Date

Covid Booster

 Yes  No  Declines

Date

How would you like to receive appointment reminders?

 Text  Email  Voice

Do you have a Surrogate Decision Maker?

Yes No

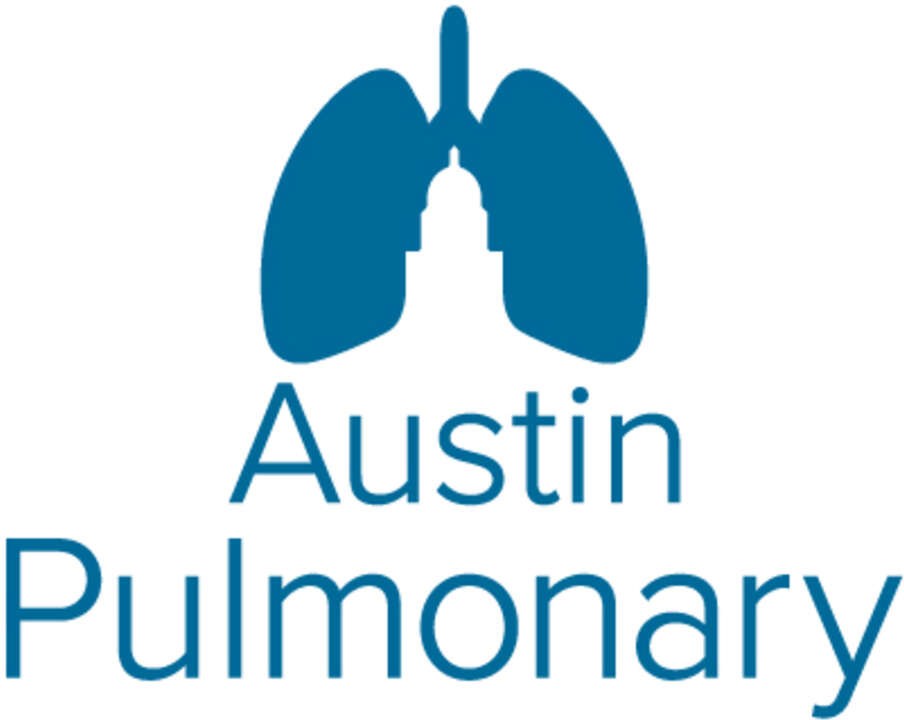
Please provide the number or email you would like to receive the information

Please let us know below what PROVIDERS to share information with or who we might need information from. Please list first and last name.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Primary Care Provider** |  | **Specialty** |  | **Phone Number** |
| **Provider Name** |  | **Specialty** |  | **Phone Number** |
| **Provider Name** |  | **Specialty** |  | **Phone Number** |
| **Provider Name** |  | **Specialty** |  | **Phone Number** |
| **Provider Name** |  | **Specialty** |  | **Phone Number** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provider Name** |  | **Specialty** |  | **Phone Number** |
| **Provider Name** |  | **Specialty** |  | **Phone Number** |

You may receive an email asking for your feedback on your recent visit at our office. IF you do NOT wish to participate please initial here



Patient Name

# Release of Information

Date Of Birth

Please list below the family and friends we may release information to.

Text Field

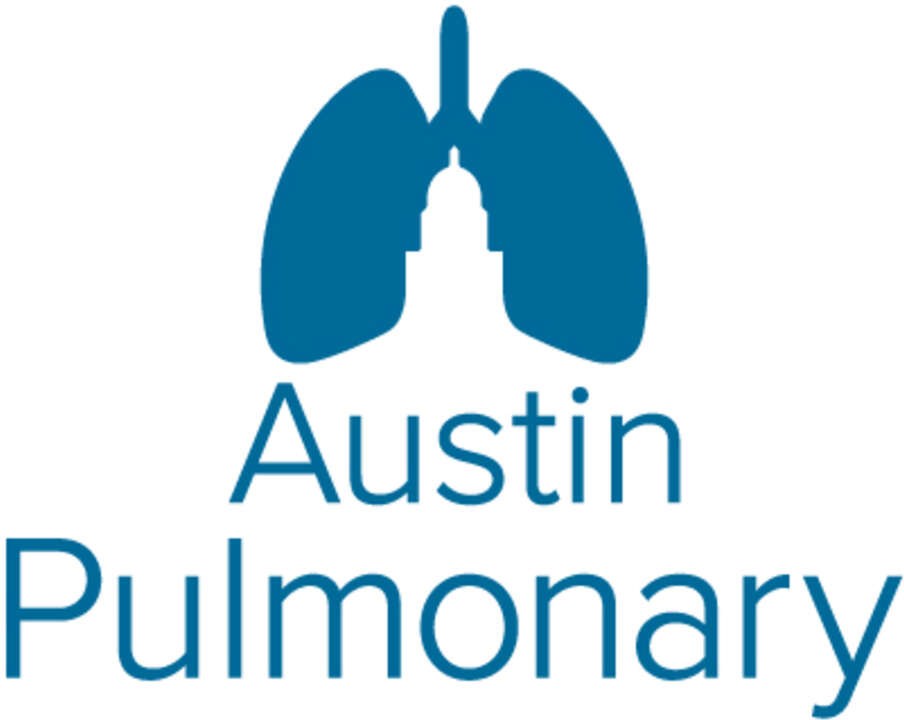
Text Field

Text Field

Text Field

Text Field

Paragraph



Popup Paragraph

# Notice of Privacy Practices

CHECK THIS BOX TO ACCEPT OUR PRIVACY PRACTICES\*\*\*\*To view the information click on the view button above

View

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Signature

# Office Policies and Procedures

Cancelled/Missed Appointments:

**There is a $75.00 charge for missed/no-show appointments for NEW PATIENTS. There is a $50.00 charge for EXISTING patients who have missed/no-showed.** Appointments with no cancellation notice received or received less than 24hours from the scheduled appointment time are considered missed appointments/no-show. The patient may not be rescheduled unless the fee is paid first. Patients who repeatedly miss appointments may be dismissed from the practice. Missed new patient appointments may be rescheduled at the physician’s discretion.

Popup Paragraph

View

Please sign below accepting the no show/cancelation fee.

Signature

Advance Practice Nurse Consent for Treatment

This facility has on staff Advance Practice Nurses (APN) to assist in the delivery of medical care. And Advance practice nurse is not a doctor. An APN is a registered nurse who has received advanced education and training in the provision of health care. And APN can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance nurse may treat minor lacerations and other minor injuries. I have read the above, and hereby consent to the services of an Advance Practice Nurse for my health care needs. I understand that at any time I can refuse to see the APN and request to see the Physician

Signature