MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

5050 POPLAR AVENUE, SUITE 800
MEMPHIS, TN 38157
(901) 276-2662
www.mspulmonary.com

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS		ETHNICITY
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER		CITY, STATE ZIP		RACE
MARITAL STATUS	STUDENT STATUS ☐Full-Time ☐Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP			SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐Full-time ☐Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

I authorize medical treatment by my physician. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health insurance benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing. I have received a copy of the Mid-South Pulmonary Specialists, P.C. Notice of Privacy Practices for Health Related Information.

ARE YOU HISPANIC OR LATINO--YES/NO

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
MEDICATION VERIFICATION SHEET

PATIENT NAME _____ CHART/MRN# _____

DATE OF VISIT _____ ALLERGIES: _____

NAME OF PHARMACY _____ Pharmacy Phone #_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.
(INCLUDING INHALERS AND VITAMINS)

	MEDICATION NAME	DOSAGE/STRENGH/MG	FREQUENCY (times per day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

ARE YOU CURRENTLY TAKING ANY FORM OF BIRTH CONTROL? YES___ NO___

_____ _____
SIGNATURE DATE

Rev. 10.3.19

NAME: _____ **MRN:** _____

PLEASE PLACE A CHECK MARK BESIDE ANY SYMPTOM YOU HAVE HAD IN THE PAST TWO WEEKS

1. _____ Have you had chills?
2. _____ Have you had fever?
3. _____ Have you had night sweats?
4. _____ Have you been hoarse?
5. _____ Have you had a sinus infection?
6. _____ Do you snore at night?
7. _____ Have you had a sore throat?
8. _____ Have you had chest pain?
9. _____ Have you had swelling in your hands or feet?
10. _____ Have you felt your heart racing?
11. _____ Have you had indigestion?
12. _____ Do you take birth control? If yes, what type?_____
13. _____ Have you had a rash?
14. _____ Have you been dizzy?
15. _____ Are you excessively sleepy during the day?
16. _____ Have you had a headache?
17. _____ Have you passed out?
18. _____ Have you had a cough?
19. _____ Have you coughed up blood?
20. _____ Do you wake up during the night short of breath?
21. _____ Are you short of breath at rest?
22. _____ Are you short of breath during activity/walking?
23. _____ Are you short of breath lying down?
24. _____ Have you heard yourself wheeze?
25. _____ Do you bruise easily?
26. _____ Do you smoke? _____ Yes _____ No. If yes, how much per day? _____
27. _____ Are you a former smoker? ___Yes ___ No If, yes, how many YEARS did you smoke? _____
    How many PACKS per day did you smoke? _____
28. _____ Do you chew tobacco? Y/N Smoke electronic cigarettes? Y/N
29. _____ Have you had any surgical procedures since your last visit? If so, what _____
30. _____ When was your last flu shot? _____
31. _____ Have you ever had a pneumonia shot? If yes, when? _____

Do you have an Advanced Directive? ___YES ___NO

(Legal documents that allow you to plan and make your own end-of life wishes known in the event that you are unable to communicate.)

SIGNATURE: _____ Date: _____

DOB: ____/___/____

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
PATIENT HEALTH HISTORY

Patient Name_____ Date_____
Address_____ Date of Birth_____
_____ Social Security Number_____

Explain why you are here to see the doctor today._____
_____
_____

Past Medical History

List the date of your most recent vaccinations
Flu_____
Pneumonia_____
Tetanus_____

List all **ALLERGIES**
_____
_____
_____

Check if you have had the following conditions or procedures.

Asthma	___	Appendectomy (appendix)	___
Emphysema	___	Hysterectomy (uterus)	___
COPD	___	Cholecystectomy (gall bladder)	___
Sarcoidosis	___	Sinus surgery	___
Pulmonary Fibrosis	___	Lung surgery	___
Collapsed lung	___	Heart Surgery	___
Histoplasmosis	___	Aneurysm surgery	___
Tuberculosis	___	Bronchoscopy	___
Chronic bronchitis	___	Cataract surgery	___
Bronchiectasis	___	Colon Surgery	___
Heart Disease	___	Prostate Surgery	___
Hypertension	___	Brain Surgery	___
Blood clot-lung	___	Tracheostomy	___
Cancer	___	Lung biopsy	___
Rheumatoid Arthritis	___		
Scleroderma	___		
Lupus	___		
Thyroid Disorder	___		
Sleep Apnea	___		
Sinusitis	___		
Cataracts	___		
Glaucoma	___		
Seizure	___		
Cystic Fibrosis	___		
Sickle Cell Disease	___		
Alpha-1 Antitrypsin Deficiency	___		
Acid reflux (GERD)	___		
HIV/AIDS	___		
Stroke	___		
Hepatitis	___		
Diverticulitis	___		
Ulcers	___		
Diabetes	___		

List any other surgeries, procedures or medical problems:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History

Check if any of your family members (mother, father, brother, sister, children) had any of the following medical conditions:

Diabetes	___	Emphysema	___
Stroke	___	Lung Cancer	___
Heart Disease	___	Asthma	___
Blood Clots	___	Pulmonary fibrosis	___
Hypertension	___	Cystic Fibrosis	___
Cancer	___	Tuberculosis	___

Social History

Have you ever smoked? Y N How much? _____ packs per day for _____ years

Do you drink alcoholic beverages? Y N How much? _____

Have you ever been exposed to chemicals, dusts or fumes? Y N What types of work have you done in your lifetime? _____

_____

System Review. Check if you have experienced any of the following in the past month.

General
- weight loss ___
- weight gain ___
- weakness ___
- fatigue ___
- fever ___
- rash ___
- hair loss ___

Head and Neck
- headache ___
- vision changes ___
- hearing loss ___
- earache ___
- nasal stuffiness ___
- sinusitis ___
- nosebleed ___
- sore throat ___
- hoarseness ___
- bleeding gums ___
- swollen glands ___
- goiter ___

Musculoskeletal
- joint pain ___
- arthritis ___
- gout ___
- muscle pain ___
- muscle cramps ___
- muscle weakness ___

Hematologic
- anemia ___
- easy bruising ___
- blood clots

Breasts
- lumps ___
- pain ___
- nipple discharge ___

Cardiac
- high blood pressure ___
- chest pain ___
- shortness of breath ___
- leg swelling ___
- palpitations ___
- passing out ___
- aneurysm ___

Gastrointestinal
- heartburn ___
- loss of appetite ___
- nausea ___
- vomiting ___
- vomiting blood ___
- bloody bowel movements ___
- diarrhea ___

Neurologic
- fainting ___
- seizure ___
- headache ___
- numbness ___
- weakness ___
- tremor ___
- memory loss ___

Endocrine
- thyroid problems ___
- goiter

Respiratory
- wheeze at rest ___
- wheeze with activity ___
- cough ___
- sputum production ___
- coughing up blood ___
- chest pain ___
- shortness of breath
  - at rest ___
  - lying down ___
  - at night ___
  - with activity ___

Genitourinary
- frequent urination ___
- painful urination ___
- bloody urine ___
- incontinence ___
- prostate problems ___
- heavy menstrual period ___
- vaginal discharge ___

Sleep Disorders
- snoring ___
- stop breathing during sleep ___
- daytime sleepiness ___
- never feel rested ___
- frequent naps ___
- fall asleep while driving ___
- early morning headache ___
- leg swelling ___

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: _____ SS#: _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION CONTAINED IN MY MEDICAL RECORD TO THE FOLLOWING PERSONS:

_____

_____

I authorize the practice to disclose or provide protected health information directly to me at the email address, fax number, phone number, cell phone number, or alternative address that I have indicated below. I am also allowing Mid-South Pulmonary Specialists to leave a message on my answering machine or with the person answering the telephone regarding appointments, etc. I understand that it is my responsibility to notify the practice of my preferred method of communications or any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, and carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

☐ **Cell phone:** ☐ **email address:** ☐ **mail:** ☐ **fax number:** ☐ **other phone:** ☐ **text message:**

_____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Entire patient record; or, check only those items of the record to be disclosed:

- ☐ Office notes
- ☐ Lab results, pathology reports
- ☐ X-rays
- ☐ Financial history report (previous 3 yrs. only)
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Only send the following: _____

PURPOSE OF DISCLOSURE (please state the purpose of the disclosure or check patient request):

☐ **Patient Request** ☐ **Other (please specify):** _____

When requesting information to be disclosed, please specify the format in which you would like the PHI provide to you. We will accommodate your request, if possible. Please be advised that there may be costs involved in providing the PHI requested.

☐ Paper copy ☐ electronic copy via the following: ☐ CD ☐ flash drive ☐ other means: _____

By signing below, I agree with the following information:

Expirations or termination of authorization – This authorization will need to be renewed every twelve (12) months, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.
Please list desired expiration date: _____
Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in-person or by mailing a written request to the practice, attn.: Compliance Office.
Non-Conditioning statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.
Re-disclosure Statement: I understand that the practice has no control regarding persons who may have access to the mailing address, email address, telephone, cell or fax number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

I understand that authorizing disclosure of this health information is voluntary. I do not need to sign this form to assure treatment. HOWEVER, IF THIS AUTHORIZATION IS NEEDED FOR PARTICIPATION IN A RESEARCH STUDY, MY ENROLLMENT IN THE STUDY MAY BE DENIED. Also, if this authorization is needed for the sole purpose of creating protected health information to disclose to a third party, my treatment may be denied.

I understand I am entitled to a copy of this form. I have seen and had an opportunity to read the notice of privacy practices for health related information.

_____ _____
Signature of patient or legal representative Date

_____
Relationship to patient