

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)

<u>MEDICATION NAME</u>	<u>DOSAGE/STRENGTH/MG</u>	<u>FREQUENCY (times per day)</u>
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

HIPAA NOTICE OF PRIVACY PRACTICES
MID-SOUTH PULMONARY & SLEEP SPECIALISTS P.C.

This Notice of Privacy Practices describes how your protected health information (PHI) may be used and disclosed by Mid-South Pulmonary & Sleep Specialists, PC and outlines your rights regarding that information. We may use and share your PHI for purposes of treatment, payment, and healthcare operations, as permitted by law. You have the right to access, request copies of, and request corrections to your PHI, as well as the right to request restrictions on how your information is used or shared. We are committed to protecting the confidentiality of your PHI and will notify you of any significant changes to this notice. My information can be released to the following people listed below:

This form stays in effect for twelve months unless otherwise specified.

If you have concerns or wish to file a complaint regarding the handling of your PHI, please contact Administrator, 5050 Poplar Ave., Suite 800, Memphis, TN 38157 (901) 276-2662 or the U.S. Department of Health and Human Services. This notice is effective as of date below. I have read and understand my HIPAA privacy rights.

Patient Name/Representative

Signature

Date

Patient DOB _____

MRN _____

NAME: _____ DOB: _____ 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 had a cough?
18. _____ Have you coughed up blood?
19. _____ Do you wake up during the night short of breath?
20. _____ Are you short of breath at rest?
21. _____ Are you short of breath during activity/walking?
22. _____ Are you short of breath lying down?
23. _____ Have you heard yourself wheeze?

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.)

-----PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS-----

24. Do you smoke? Yes _____ No _____ If yes, how much per day? _____
25. Are you a former smoker? Yes _____ No _____ If yes, how many YEARS did you smoke? _____
How many PACKS per day did you smoke? _____
26. Do you chew tobacco? Yes _____ No _____ Smoke electronic cigarettes? Yes _____ No _____
27. Have you had any surgical procedures since your last visit? If so, what _____
28. What date was your last flu shot? _____
29. Have you ever had a pneumonia shot? If yes, when? _____
30. Do you use an Oxygen machine at home? Yes _____ No _____
31. Do you wear/use a CPAP machine at home? Yes _____ No _____
32. Have you had a fall in the last 12 months? Yes _____ No _____ If so, did it result in an injury? Yes or No

SIGNATURE: _____ Date: _____

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

List all ALLERGIES

Flu _____
Pneumonia _____
Tetanus _____

Check if you have had the following conditions or procedures.

Asthma	
Emphysema	
COPD	
Sarcoidosis	
Pulmonary Fibrosis	
Collapsed lung	
Histoplasmosis	
Tuberculosis	
Chronic bronchitis	
Bronchiectasis	
Heart Disease	
Hypertension	
Blood clot-lung	
Cancer	
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	

Appendectomy (appendix)	
Hysterectomy (uterus)	
Cholecystectomy (gall bladder)	
Sinus surgery	
Lung surgery	
Heart Surgery	
Aneurysm surgery	
Bronchoscopy	
Cataract surgery	
Colon Surgery	
Prostate Surgery	
Brain Surgery	
Tracheostomy	
Lung biopsy	

List any other surgeries, procedures or medical problems:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

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 ___