PULMONARY DISEASE
CRITICAL CARE MEDICINE
SLEEP DISORDERS MEDICINE
PULMONARY HYPERTENSION
INTERVENTIONAL BRONCHOSCOPY
ADULT CYSTIC FIBROSIS
CLINICAL RESEARCH

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Welcome!! THANK YOU for choosing our practice! Included below is information to help you prepare for your visit.

For every appointment with our office, please check in 20 minutes prior to your scheduled appointment time, this will allow us to ensure we have all the necessary information for each visit with your provider.

In an effort to provide you with the best possible care, our office will require;

First Appointment

- ☐ Picture ID
- ☐ Insurance cards
- ☐ Pharmacy Information (Name and Phone number)
- ☐ If your insurance requires a copay, please be prepared to pay at the time of your visit.
- ☐ Completed New Patient Packet (Attached)
- ☐ Medication List (Attached)
- ☐ Copies of your most recent chest imaging (Chest X Ray, CT Chest, PET Scan, etc.)
- ☐ Any pertinent medical records that will assist in your visit
- ☐ If you are scheduled for a breathing related concern, please refrain from using a rescue inhaler/nebulizer 2 hours prior to appointment time as we may perform a Spirometry breathing test

Every Follow Up Appointment

- ☐ Completed brief questionnaire (Provided upon check-in)
- ☐ Copy of current medication list
- ☐ If your insurance requires a copay, please be prepared to pay at the time of your visit.
- ☐ Copies of your most recent chest imaging (Chest X Ray, CT Chest, PET Scan, etc.)
- ☐ If you are also scheduled for a Spirometry breathing test, please refrain from using a rescue inhaler/nebulizer 2 hours prior to appointment time

If you have been treated for a pulmonary/respiratory condition at Urgent Care, ER or been hospitalized since your last appointment, please notify our office so we may obtain the records for your appointment.

Full Pulmonary Function Test

- ☐ Copy of current medication list
- ☐ Refrain from using a rescue inhaler/nebulizer 4 hours prior to appointment time
- ☐ Refrain from smoking 1-hour prior to appointment

Thank you for the opportunity to be a part of your health care team!

Pulmonary Associates, PA

Mesa
5151 E. Broadway Rd.
SUITE #107
Mesa, AZ 85206
P: 480-290-7000
F: 480-325-3461

Bell
3811 E. Bell Rd.
SUITE #107
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P: 602-340-1689
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2550 W. Union Hills Dr.
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PULMONARY ASSOCIATES, PA

New Patient Medical History Form

Name: _____ Date of Birth: ____/____/_____

Date: ____/____/_____ Referring Provider: _____ Primary Care Provider: _____

Why are you seeing a pulmonary (lung) provider?

_____

_____

_____

_____

_____

Have you recently been hospitalized? ☐YES ☐NO **When:** _____/_____month/year **Where:** _____
Have you recently been in Urgent Care? ☐YES ☐NO **When:** _____/_____month/year **Where:** _____

Have you recently had any of the following:

☐ Chest X Ray **When:** _____/_____month/year **Where:** _____
☐ Chest CT (cat scan) **When:** _____/_____month/year **Where:** _____
☐ Echocardiogram **When:** _____/_____month/year **Where:** _____

Have you had exposure to chemicals? ☐YES ☐NO **Type:** _____
Have you recently traveled outside of the country? ☐YES ☐NO **Where:** _____

Have you had Flu Vaccine(s)? ☐ YES ☐ NO ☐ I do not wish to have vaccines
Please list the last 2 FLU Vaccine(s): _____/_____month/year, _____/_____month/year

Have you had Pneumonia Vaccine(s)? ☐ YES ☐ NO ☐ I do not wish to have vaccines
Which one and when? ☐ Prevnar 13 _____/_____month/year, ☐ Pneumovax _____/_____month/year

PULMONARY ASSOCIATES

REVIEW OF SYSTEMS (R O S)

Name: _____ **DOB**: ____/____/____ **Date**: ____/____/____

Please check any symptoms you are CURRENTLY experiencing below:

GENERAL
- ☐ **NONE**
- ☐ Fatigue (easily tired)
- ☐ Malaise (generally unwell)
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain

ENT
- ☐ **NONE**
- ☐ Earache
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Postnasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat

CARDIOVASCULAR
- ☐ **NONE**
- ☐ Chest Pain
- ☐ Claudication (leg pain with activity)
- ☐ Edema (lower leg swelling)
- ☐ Palpitations
- ☐ Orthopnea (shortness of breath when lying down)

RESPIRATORY
- ☐ **NONE**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Pain with Breathing
- ☐ Wheezing

GASTROINTESTINAL
- ☐ **NONE**
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

MUSCULOSKELETAL
- ☐ **NONE**
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness

DERMATOLOGIC
- ☐ **NONE**
- ☐ Hives
- ☐ Rash
- ☐ Itching
- ☐ Skin Lesions

NEUROLOGICAL
- ☐ **NONE**
- ☐ Dizziness
- ☐ Numbness in Hands/Feet
- ☐ Weakness in One/Both Arms/Legs
- ☐ Abnormal Gait (unusual walking)
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors

PSYCHOLOGICAL
- ☐ **NONE**
- ☐ Anxiety
- ☐ Depression

HEMATOLOGIC/LYMPHATIC
- ☐ **NONE**
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Lymph Nodes/Glands

SLEEP
- ☐ **NONE**
- ☐ Insomnia
- ☐ Wake with Gasping/Choking
- ☐ Sleepiness During the Daytime
- ☐ Restless Sleep
- ☐ Snoring

IMMUNOLOGIC
- ☐ **NONE**
- ☐ Seasonal Allergies
- ☐ Contact Allergies
- ☐ Food Allergies
- ☐ Inhalation Allergies

GENITOURINARY
- ☐ **NONE**
- ☐ Increase in Urination
- ☐ Urination During the Night

WHEN FORM IS COMPLETE, PLEASE KEEP AND HAND TO YOUR MEDICAL ASSISTANT WHEN CALLED BACK.

PERSONAL MEDICAL HISTORY

PULMONARY
- ☐ Allergies
- ☐ Alpha 1 Antitrypsin
- ☐ Asbestosis
- ☐ Asthma
- ☐ Recurrent Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Nodule(s)
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Valley Fever (Coccidioidomycosis)

CARDIOVASCULAR
- ☐ Anemia
- ☐ Atrial Fibrillation
- ☐ Blood Clots/DVT
- ☐ Chest Pain (Angina)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Elevated Cholesterol
- ☐ High Blood Pressure (HTN)
- ☐ Heart Attack (MI)
- ☐ Murmur/Heart Valve Disease
- ☐ Stroke

GASTROINTESTINAL
- ☐ Acid Reflux (GERD)
- ☐ Hepatitis, Type: C B A

RHEUMATOLOGIC
- ☐ Lupus
- ☐ Rheumatoid Arthritis

GENITOURINARY
- ☐ Kidney Stones
- ☐ Chronic Kidney Disease

NEUROLOGIC/PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Dementia
- ☐ Depression
- ☐ Insomnia
- ☐ Restless Leg Syndrome

METABOLIC
- ☐ Diabetes, Type: 1 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Osteoarthritis

OTHER
- ☐ Cancer, Type: _____
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Immunoglobulin Deficiency

Additional Medical History:

_____

_____

_____

PULMONARY	YEAR
☐ Bronchoscopy	_____
☐ Lobectomy: **L R**	_____
☐ Lung Biopsy	_____
☐ Lung Surgery	_____
☐ Tonsillectomy	_____
☐ Adenoidectomy	_____
☐ Tracheostomy	_____
☐ Sinus Surgery	_____

CARDIOVASCULAR	YEAR
☐ CABG/Open Heart	_____
☐ Cardiac	_____
☐ Cardiac Stent	_____
☐ Pacemaker	_____
☐ Catheterization	_____

GASTROINTESTINAL	YEAR
☐ Appendix Removal	_____
☐ Gall Bladder Removal	_____
☐ Hernia Repair	_____

GENITOURINARY	YEAR
☐ Dialysis	_____
☐ Kidney Stone Removal	_____
☐ Kidney Removal	_____

MUSCULOSKELETAL	YEAR
☐ Back Surgery	_____
☐ Hip **L R**	_____
☐ Knee Replacement **L R**	_____
☐ Neck Surgery	_____
☐ Rotator Cuff **L R**	_____
☐ Repair:	_____
☐ Replacement:	_____

FEMALE	YEAR
☐ C-Section (Cesarean)	_____
☐ Hysterectomy	_____
☐ Tubal Ligation	_____

MALE	YEAR
☐ Prostate Surgery	_____

OTHER	YEAR
☐ Cataract Surgery	_____
☐ LASIK	_____
☐ Lymph Node Biopsy	_____
☐ Mastectomy	_____
☐ Thyroidectomy	_____

Additional Surgical History:

_____

_____

_____

FAMILY HISTORY

☐ No Significant Family History ☐ Adopted

PULMONARY

☐ Alpha 1 Antitrypsin	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Asthma COPD Emphysema	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Pulmonary Fibrosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Pulmonary Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Sarcoidosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Sleep Apnea	☐ Father	☐ Mother	☐ Brother	☐ Sister

CANCER

☐ Breast Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Colon Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Lung Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Other Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister

CARDIOVASCULAR

☐ Coronary Artery Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Venous Thrombosis	☐ Father	☐ Mother	☐ Brother	☐ Sister

RHEUMATOLOGIC

☐ Rheumatoid Arthritis	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Lupus	☐ Father	☐ Mother	☐ Brother	☐ Sister

NEUROLOGICAL

☐ Alzheimer's	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Dementia	☐ Father	☐ Mother	☐ Brother	☐ Sister

ENDOCRINE

☐ Diabetes	☐ Father	☐ Mother	☐ Brother	☐ Sister

SOCIAL

☐ Alcoholism	☐ Father	☐ Mother	☐ Brother	☐ Sister
☐ Drug Abuse	☐ Father	☐ Mother	☐ Brother	☐ Sister

Additional Family History: _____

_____

SOCIAL HISTORY

Do you use Tobacco? ☐ YES ☐NO ☐ FORMER / **Type of Tobacco:** ☐ Cigarettes ☐ Cigar ☐Pipe ☐Chew ☐Smokeless
Overall Daily Average: _____ pack(s)/pipe/can, **Total # of Years Used:** _____, **Date Quit:** ___/____/_____

Do you drink Alcohol? ☐ YES ☐NO ☐ FORMER / **Type of alcohol:** ☐ Beer ☐ Wine ☐ Liquor
How Much: _____ Beers/Glasses/Drinks, **How Often:** ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly, **Date Quit:** ___/____/_____

Do you drink Caffeine? ☐ YES ☐NO ☐ FORMER / **Type of Caffeine:** ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks
How Much: _____ Cups/Ounces

Do you use Recreational Drugs? ☐ YES ☐NO ☐ FORMER / **Type:** _____,
How Often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly, **Date Quit:** ___/____/_____

Do you Exercise? ☐ YES ☐NO / **Type of Exercise:** _____,
How Much: _____, **How Often:** ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Occupation: _____ / **Marital Status:** ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed
Lived in Arizona Since: _____(year) / **Domestic Partner:** ☐ Opposite Sex ☐ Same Sex
# of Children: _____ ☐ Sons ☐ Daughters / **Pets:** ☐ Yes ☐ No, **Type:** _____

MEDICATION LIST

Name _____ Date of Birth _____ Date _____

Pharmacy _____ Location _____ Phone Number (____) _____

Any **allergies** to medicines: Yes No Unknown

If Yes, what medicine(s): _____ What reaction(s): _____

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICINES, VITAMINS AND SUPPLEMENTS

Medication Name	Strength (mg, mcg, etc.)	How Often (1 x day, 2 x day, etc.)	Reason for taking (heart, blood pressure, etc.)

Pulmonary Associates Office and Financial Policies:

Thank you for choosing Pulmonary Associates, PA. for your medical needs. We are committed to providing you with the highest quality medical care and maintaining a good physician-patient relationship is our primary goal. Even when insurance is in place, patients are ultimately responsible for charges associated with their care. As your provider, we feel it is our responsibility to let you know in advance of our office and financial policies. This will allow for a good flow of communication and enable us to achieve our physician-patient relationship goal. We realize you have choices for your medical care, and we sincerely appreciate you choosing Pulmonary Associates, PA.

For our patient's convenience, we participate in most major health plans. Our business office will submit claims for services rendered and will assist you in any reasonable way in getting your claims paid. It is the patient's responsibility to provide all necessary information during the appointment scheduling process as well as ensuring there is an authorization and/or referral form from your PCP if it is required by your insurance.

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

FEES AND SURCHARGES

☐ **$50.00 Fee for Form Completion:**
There will be a fee of $50.00 for all forms needing completion outside an office visit.

☐ **FEES for Processing Medical Records Request Forms:**
1-10 pages = $10.00
11-20 pages = $11.00 - $20.00
21+ pages = $21.00 +

- Merical Records request are $1.00 / Page
- In addition to the "per page fee", a $15.00 processing fee will be charged

☐ **Administrative Collection Fees:**
Any outstanding balances sent to a third-party collection agency will incur a 20% fee. In addition, you may not be able to make future appointments until this balance is discussed with our billing department.

☐ **$25.00 NSF Fee for Returned Checks:**
All returned checks will incur an additional $25.00 fee, and we will require alternative payment for all future visits.

Please **SIGN** and **DATE** below acknowledging your notification of these fees:

Print Name: _____

Signature: _____ **Date:** ___/____/_____

PA FORM #D
Revised 2023

5151 E. Broadway Rd
STE 107
Mesa, AZ 85206
P: 480-290-7000
F:480-325-3461

3811 E. Bell Rd
STE 107
Phoenix, AZ 85032
P: 602-340-1689
F: 602-340-1853

2550 W. Union Hills Dr
STE 390
Phoenix, AZ 85027
P: 602-443-4068
F: 623-434-8310

Authorization to Release Information

The purpose of this form is for YOU (patient) to give Pulmonary Associates permission to release information regarding your care to the Family/Friend listed below. Please review, complete, sign & date and return to our front desk.
(Ex: prescription pick-up, appointment coordination, record retrieval, etc…)

Patient Name: _____ Date Of Birth: _____ SSN #:_____

I, _____, authorize Pulmonary Associates, PA to communicate with the person/persons listed below regarding my care and treatment.

1. _____ _____
Name **Address**
Telephone #: (_____) _____ _____**85**_____
City/State **Zip Code**

2. _____ _____
Name **Address**
Telephone #: (_____) _____ _____ **85**_____
City/State **Zip Code**

___ Verbal Communication

___ Other (Please Specify): _____

The purpose of this release: COORDINATION OF CARE

Pulmonary Associates, PA is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time (in writing) with the exception that action has already been taken on the consent. Unless otherwise specified, this consent expires one year following date of signature.

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization of the release of medical or other Information for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." I understand records or information in the records will not be covered under Federal Privacy Laws should the RECEIPIENT of my records re-disclose them. Note: A photocopy and/or facsimile of this consent shall be considered valid as original.

_____ _____
Patient/Parent/Guardian Signature **Form to EXPIRE 1 year from original signed date**

Zero Tolerance for Abuse Policy

Our practice is committed to providing high-quality care in a safe, respectful, and supportive environment for both patients and staff.

We operate a **zero-tolerance policy** toward physical or verbal abuse of our staff. This includes, but is not limited to, aggressive behavior, threats, shouting, swearing, discriminatory or offensive language, intimidation, or any form of physical contact.

Any behavior that makes our staff feel unsafe or disrespected will not be tolerated. Patients who engage in such conduct may be asked to leave the premises, have their appointment ended, be restricted from future services, or, where appropriate, the incident may be referred to security or law enforcement.

We understand that illness, pain, and stress can be challenging. However, abusive behavior toward staff is never acceptable. If you have concerns about your care, we encourage you to raise them calmly with a member of our team so they can be addressed appropriately.

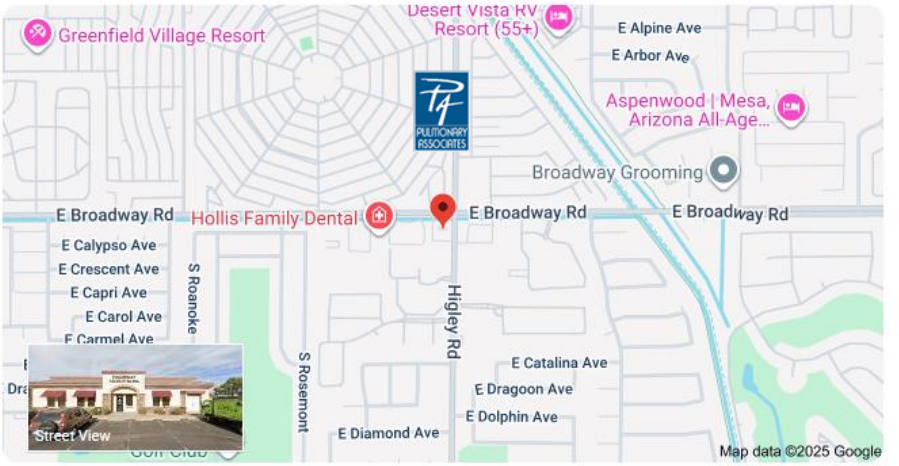
Thank you for your understanding and cooperation in helping us maintain a safe and respectful environment for everyone.

Please SIGN and DATE below acknowledging your notification of this policy.

Print Name: _____ DOB: _____

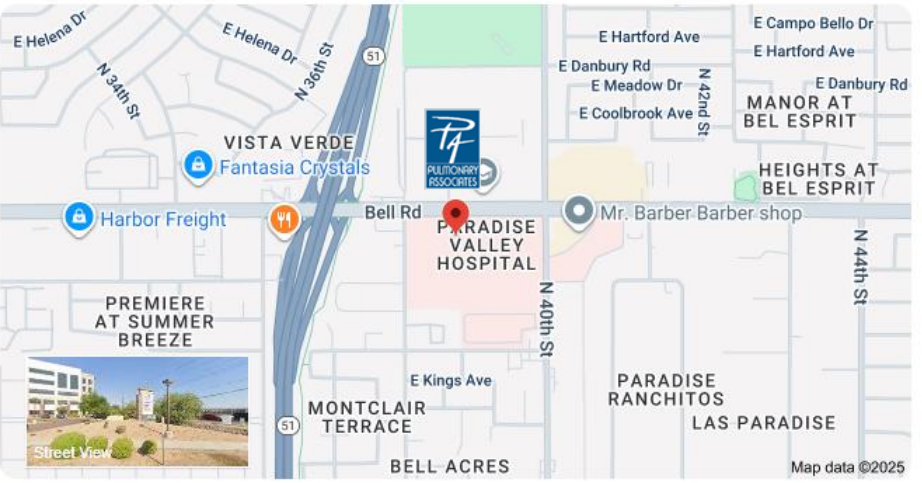
Signature: _____ Date: _____

OFFICE LOCATIONS



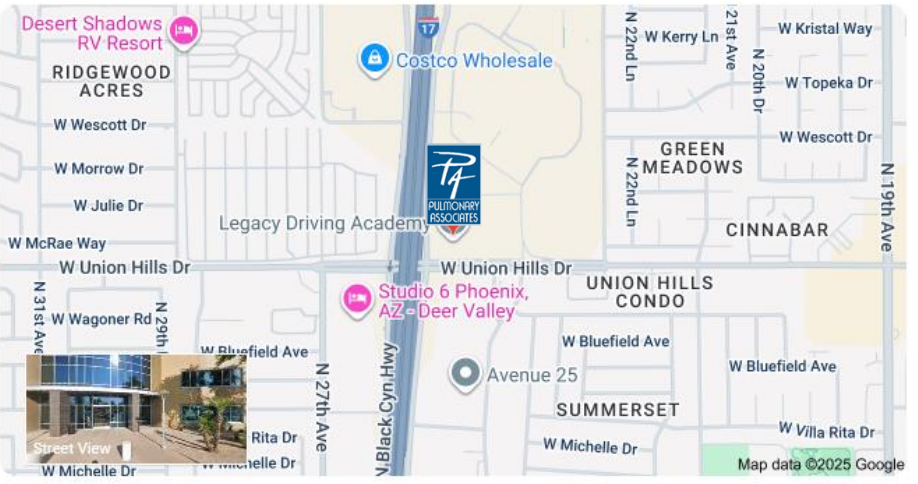
5151 E Broadway Rd STE 107

Mesa, AZ 85206



3811 E Bell Rd Ste 107

Phoenix, AZ 85032



2550 W Union Hills Dr #390

Phoenix, AZ 85027