THE
LUNG GROUP
PENSACOLA

4700 Bayou Blvd, Suite 6, Pensacola, FL 32503
P. (850) 477.9253 | **F.** (850) 494.9843 | **lunggroup.org**

New Patient Paperwork

Patient Name: ________________________________

Please fill out the enclosed paperwork and return it in the self-addressed stamp envelope. We need this paperwork as soon as possible; no later than one week prior to the appointment. Our priority is quality and efficiency. This paperwork allows us to input your information into our Electronic Medical Records which in turn provides more time for you and the physician during your appointment. **If any of the provided information is not correct, simply line through it and provide the correct information.**

If the paperwork is not returned to the office, your appointment will be rescheduled due to the time it takes to input this important information.

If you have any questions, please call us at (850) 477-9253.

Thank you,

Physicians and Staff at the Pensacola Lung Group

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WELCOME to the Pensacola Lung Group & Sleep Science Center! The following details are provided so you will know and understand our services and policies.

SERVICES: We are a specialty practice and our scope of practice focuses on breathing-related (pulmonary), critical care medical and sleep disorder issues. We work in concordance with your primary care doctor who provides your routine medical care.

OFFICE AND TELEPHONE HOURS: We are located in Suite 6 at 4700 Bayou Blvd, in the Gulf Coast Office Center (behind Coastal Bank). Our office hours are Monday through Thursday, 8am to 5pm. To speak with someone from our office, telephone hours are from 9am to 4pm. However, you can leave a message at any time, day or night through our automated telephone system.

APPOINTMENTS:

- Please arrive at least 30 minutes *prior* to your initial scheduled appointment. This time will allow for completion of paperwork and check in by the nurse.
- If you do not arrive by the time indicated *AND* you are more than 15 minutes late, *YOU RISK HAVING YOUR APPOINTMENT RESCHEDULED*.
- Sleep Study patients please arrive at 8:00pm. The closet parking to the Sleep Science Center is directly in front of the building.
- If you had a chest or sinus x-ray or CT scans taken any place OTHER than Sacred Heart, *please bring the actual films with you to your Doctor's appointment* ***only*** *unless you have made other arrangements for them to be delivered*.
- Bring actual *prescription medicines* you are currently taking to your Doctor's appointment.
- Bring your *Insurance ID card(s)*.
- *Bring a picture ID* (i.e. driver's license, state ID card, Military ID, or Student ID).
- A map to our office is enclosed.

REGISTRATION: If you received the "New Patient Packet" in the mail, please complete the paperwork prior to your appointment and mail it back. If you did not receive the "packet", you can expect to complete the following paperwork upon your arrival:

1. A Patient Information form
2. A Medical History form
3. If appropriate, other Miscellaneous paperwork

FINANCIAL POLICY

- Pensacola Lung Group accepts payments by cash, check, and most major credit cards.
- *Account balances are collected upon check out.*
- As mandated by your insurance company(ies), *co-pays, deductibles and percentages of charges are collected upon check-out.*
- *Non-covered services*, as identified by your insurance company, will be collected at the time the service is rendered.
- For private pay *(no insurance), payment in full is expected at the time of service.*

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- If you are a member of a managed care program, and a referral is required from your primary care provider for the services you are to receive, *an authorization number must be received PRIOR to services performed. Should the authorization not be in place at the time of service, your appointment will be rescheduled.* Please contact your primary care provider personally to assure the authorization is issued to you and bring it to your appointment or to our office directly.

A Billing Department representative is available during regular business hours to discuss payment option should you desire this information. Please contact them directly to make payment arrangements prior to appointment times and prior to receiving services. They may be reached by calling 477-9253 and pressing option 7.

INSURANCE POLICY: Thank you in advance for bringing your Insurance card(s) with you to your scheduled appointment. Copies will be made for our records.

- We can bill your claims for you if we are a participating provider with your insurance company. However, please note: *If your insurance company does not remit payment within 45 days from the date of service, your personal payment of the bill in full is expected, unless other arrangements have been made with the billing department.* Should your insurance pay after your payment is received, you will receive a timely, full refund.
- *Payment in full is expected at the time services are rendered if we are not a participating provider with your insurance company, unless prior arrangements have been made with the billing department.*

Again, we welcome you to our practice and we look forward to providing you with excellent health care.

Sincerely,
The Physicians and Staff of the Pensacola Lung Group

Signing below authorizes us to release information regarding your claim and gives us the consent to bill your insurance company and receive payment directly from them. It also gives us the consent to send information to them to process your claim if additional information is needed from them to do so. Thank you!

____

Patient Signature Date

Note: Thank you in advance for being considerate of other patients by *contacting us when you know you must reschedule or cancel your appointment. Giving at least 48-hours' notice is expected.* Doing so will allow for the time to be filled with other patients who are on our waiting list. *Not doing so* may result in the loss of your opportunity to be rescheduled.

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Patient Information/Updated Information

Patient Name: ________________________________

Sex: Male / Female Date of Birth: __________

Social Security #: ______-____ -______ Race: ___________

Marital Status: ____________

Street Address: ____________________

____

Home Phone #: (____)______________

Other Phone: (____)______________

______________________________	________________________________
Referring Physician	**Primary Care Physician**

Do you currently smoke? Y / N (Please Circle One)

May we consult these physicians? Yes No (circle one)

May we forward a copy of your doctor's note/results to these physicians? Yes No (circle one)

Have you ever been evaluated at a Sleep Disorder Center before? If yes, where____________________

May we obtain a copy of your previous sleep study? Yes No N/A (circle one)

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Pharmacy (Name and Location): ____

____

	Medication	Strength	How Many	How Often
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Allergies	
1	
2	
3	
4	
5	

Operations: List the Name of the operation(s) and Corresponding Year(s)

________________________ Yr. _______ ________________________ Yr. _______
________________________ Yr. _______ ________________________ Yr. _______
________________________ Yr. _______ ________________________ Yr. _______
________________________ Yr. _______ ________________________ Yr. _______

4. Family History

Father: ☐ Living: Age ___ ☐ Deceased: Age ___ Illnesses: __________________
____

Mother: ☐ Living: Age ___ ☐ Deceased: Age ___ Illnesses: __________________
____

Number of Brothers: _______ Illnesses?: ____________________________________

Number of Sisters: _______ Illnesses?: ____________________________________

Number of Children: _______ Illnesses?: ____________________________________

Is there a History of Asthma: ☐ Yes ☐ No

5. Respiratory Questionnaire:

Have you been told that you have heart disease?	☐ Yes	☐ No	If Yes, what year were you told? ____________
Have you been told that you have Asthma?	☐ Yes	☐ No	If Yes, what year were you told? ____________
Have you been told you have bronchitis?	☐ Yes	☐ No	If Yes, what year were you told? ____________
Have you been told that you have emphysema?	☐ Yes	☐ No	If Yes, what year were you told? ____________
Do you consume more than one alcoholic drink per day?	☐ Yes	☐ No	If Yes, how much? ____________
Do you Smoke?	☐ Yes	☐ No	If Yes, how many? _____Pack(s)/day
Have you ever Smoked?	☐ Yes	☐ No	If Yes, what year did you quit? _____ How many? _____Pack(s)/day Total number of years smoked? ______

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Do you have Smoker's cough?	☐ Yes ☐ No		
Do you frequently cough in the morning?	☐ Yes ☐ No		
Do you have an intermittent cough?	☐ Yes ☐ No		
Do you frequently experience intermittent chest congestion?	☐ Yes ☐ No		
Do you cough up any mucus?	☐ Yes ☐ No	Color? ___________	
Breathing	Shortness of Breath?		☐ Yes ☐ No
	During moderate exertion?		☐ Yes ☐ No
	During normal activity?		☐ Yes ☐ No
	While at rest?		☐ Yes ☐ No
Wheezing	During Common Cold?		☐ Yes ☐ No
	During moderate exertion?		☐ Yes ☐ No
	During normal activity?		☐ Yes ☐ No
	While at rest?		☐ Yes ☐ No
Have you had a fever within the last month?	☐ Yes ☐ No	What was the reading? ____________	
Does your occupation expose you to any of the following?	Asbestos Dust		☐ Yes ☐ No
	Cotton Dust		☐ Yes ☐ No
	Mining Dust		☐ Yes ☐ No
	Paint, Plastic or Solvent Fumes		☐ Yes ☐ No
Have you worked around chickens?	☐ Yes ☐ No		
Do you scuba dive?	☐ Yes ☐ No		

Other Diagnosis:
(Check ALL that apply)

- ☐ Heart Attack
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Clogged Vessels
- ☐ Rheumatic Fever
- ☐ Irregular Heartbeat
- ☐ Cancer
- ☐ Bad Valve in your Heart
- ☐ Chest pain when exercising
- ☐ Pain in legs when exercising
- ☐ Enlarged Heart
- ☐ Swollen Ankles or legs
- ☐ Heart Murmur or other abnormal heart sound
- ☐ Hypertension

Other Medical Conditions not mentioned?

____

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APPOINTMENT CANCELLATION POLICY

Patient: ____

Your appointment time is reserved just for you. If you are unable to keep the scheduled appointment, please call to reschedule or cancel at least two (2) business days in advance. Doing so will provide the opportunity for another patient to schedule. The number to call is (850) 477-9253. You can call anytime, day or night, any day of the week.

Non-cancelled appointments will result in an office charge of $25.00 each.

By signing this form, you are agreeing you have read and that you understand the Appointment Cancellation Policy as written. Thank you, in advance, for the consideration given to the practice, and particularly, to other patients requesting services.

_____________________________________ (Patient Signature)

________________ (Date)

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INSURANCE: NON-COVERED SERVICES

(Non-Medicare Insurance)

Patient: ____

Please be assured the Doctors and Physician Assistant/Nurse Practitioners in this practice *will request only medically necessary services.* However, in order to assure the highest quality care for you it may be necessary to order services that your insurance may or may not cover. Should your insurance not cover, we will notify you and it will become your personal responsibility for those services. We will make every effort to avoid any services that would not be covered by your insurance.

Also, patients will be responsible for any co-pays or deductibles that are required by their insurance companies.

By signing this form, you are agreeing to pay for any services you receive that your insurance plan defines as non-covered.

_____________________________________ ________________

(Patient Signature) (Date)