PULMONARY CARE SPECIALISTS, PA

4333 N. Josey Ln., Plaza 2, Suite 207, Carrollton 75010
972-394-2971 Fax 972-492-1261

James P. Loftin, M.D. **Melissa L. Tompkins, M.D.**

Dear New Patient;

It is **very important** that you complete the following questionnaire for the appointment you have scheduled on ___________________________________. By answering all of the questions as completely as possible before your appointment, you will save considerable time in the Doctor's office. If you do not complete this paperwork prior to your appointment, **please arrive an hour early to do so**.

When you arrive for your appointment, please present a current insurance card to the receptionist. If your insurance plan requires a referral from your Primary Care Provider, please bring it with you. **If no referral is presented, the receptionist will have to re-schedule your appointment.** If you do not know if your insurance plan requires a referral, you can call the benefits phone number on your insurance card to find out.

If you have a current chest X-Ray, please bring it with you (***Dr.Tompkins requires a chest X-Ray within the last two weeks)***. If you have had a CT of the chest within the last three years, please bring the films with you. Please expect the initial visit to last at least an hour. Some visits may take longer depending on the number of breathing tests performed. After the initial visit, your appointments will generally be much shorter.

Due to a high increase of patients not showing up for their scheduled appointments and in order for us to have available times for patients in need of appointments, we will implement the following policy effective April 1, 2010. We must be called twenty-four hours in advance if you are unable to keep your appointment or **we will not be able to reschedule your appointment for a later date**. There will also be a fee of $35.00 billed directly to you and not to your insurance company.

If you have any questions, please call the office where you are scheduled. We look forward to your first visit with our caring staff.

Sincerely,

James P. Loftin, MD
Melissa L. Tompkins, MD
Kathy Johnson, PA-C
Ebonyck Simmons, NP-C

PULMONARY CARE SPECIALISTS

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NAME ____ AGE _________________________

HOME PHONE ____________________________ WORK PHONE ______________________

APPOINTMENT WITH _______________________M.D. APPOINTMENT DATE _______________

PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE.
IF YOU NEED MORE SPACE FOR ANY SECTION, PLEASE USE AN EXTRA PAGE.
IF YOU HAVE ANY PROBLEM WITH THIS FORM PLEASE CALL THE OFFICE.

Name of Address of Referring Physician

____

____

____

Name and Address of Family Physician

____

____

____

****

Please describe all of the problems that you are currently experiencing which caused you to seek treatment here today.

____

____

____

____

____

____

____

Do you have any other medical problems? NO __________ YES _________ if YES, list below.

____

____

RESPIRATORY

Have you noticed any shortness of breath? NO ________ YES ________

If YES,

How long have you noticed this? ______________________________

_______________ when sitting or resting?
_______________ when walking slowly?
_______________ when walking fast?
_______________ only when doing heavy work or physical activity?
_______________ when climbing stairs? How many flights? _____________

When you breathe, do your notice a wheeze or whistling
In your chest? NO ________ YES ________

How long have you noticed this wheezing?

_______________ all my life
_______________ over 10 years
_______________ over 1 year
_______________ just recently

How often does the wheezing occur?

______________ all the time
______________ nearly every day
______________ some every week
______________ some every month
______________ only on rare occasions

When does the wheezing occur?

______________ any time of the year
______________ seasonal (check which) _____Spring ____Summer ____ Fall ____ Winter
______________ any time day or night
______________ nighttime only
______________ only when physically active

Do you cough up any sputum or phlegm? NO ________ YES ________

If YES,

When do you cough it up?

______________ any time
______________ yellow or green
______________ brownish
______________ red-streaked (or blood streaked)

How much do you cough up?

______________ small amount- 1 tablespoon/day
______________ moderate amount- 1 tablespoon/day to ½ cup day
______________ more than ½ cup/day

Do you have a constant or bothersome cough? NO ________ YES ________
If YES, how long have you had it? ___________________________________

Do you have frequent chest colds? NO ________ YES ________
If YES, how many times per year on average? _____________
And for how many years? ___________________

Do you cough blood? NO ________ YES ________
If YES, when was the last time you coughed up blood? ____________________
Have you ever had this happen before? NO ________ YES ________

Have you ever had difficulty breathing after taking aspirin? NO ________ YES ________

Have you ever had difficulty breathing after drinking wine? NO ________ YES ________

Do you cough or experience difficulty breathing after exposure
To strong smells (fumes, smoke, dust, perfumes, Etc.?) NO ________ YES ________

Do you use a feather pillow or a down filled pillow? NO ________ YES ________

Have you been exposed to anyone with tuberculosis? NO ________ YES ________

Have you had a skin test for tuberculosis? NO ________ YES ________
If YES, when ____________________ What was the result? NEG __________ POS _______

Do you cough, produce phlegm and/or wheeze when you exercise? NO ________ YES ________

How far can you walk at a normal pace on the level?
_____________ room to room only
_____________ 1 block or less
_____________ 2 to 6 blocks
_____________ unlimited

PAST MEDICAL HISTORY

LIST ALL CONDISTIONS FOR WHICH YOU HAVE RECEIVED MEDICAL TREATMENT.
LIST ALL HOSPITAL ADMISSIONS AND SURGICAL PROCEDURES.

	CONDITION/SURGERY	DATE	TREATMENT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

List below **all** medications, eye drops, vitamins, laxatives, etc., that you take regularly or have taken during the **past month**. If name of medication is not known, please find out from your druggist the name or bring the medication with you. Include both prescription and non-prescription agents.

	NAME (IF KNOWN)	**PURPOSE FOR WHICH TAKEN**	**HOW OFTEN? IF DAILY HOW MANY A DAY?**
1.	________________	________________________	____________________________________
2.	________________	________________________	____________________________________
3.	________________	________________________	____________________________________
4.	________________	________________________	____________________________________
5.	________________	________________________	____________________________________
6.	________________	________________________	____________________________________
7.	________________	________________________	____________________________________
8.	________________	________________________	____________________________________
9.	________________	________________________	____________________________________
10.	________________	________________________	____________________________________

Do you have any drug allergies? NO _____ YES _____If YES, list below with type of reaction

	MEDICATION OR DRUG	**REACTION**
1.	_____________________________________	____________________________________
2.	_____________________________________	____________________________________
3.	_____________________________________	____________________________________
4.	_____________________________________	____________________________________

Estimate that last date that you had the following items:

Complete medical examination ....20 ___
Eye examination...............................20 ___
Blood pressure check.........................20 ___
Blood count.......................................20 ___
Flu vaccine..20 ___
Pneumonia vaccine............................20 ___

Blood sugar check for diabetes.............20__
Electrocardiogram (EKG).....................20__
X-Rays Chest.......................................20__
Mammogram..20__
Prostate Test...20__
Pap Smear..20__

SOCIAL HISTORY

Are you: Single _____________ Married _________ Separated _______
Divorced__________ Widowed _________ Widower ________

Have you ever used tobacco? NO __________ YES __________

If YES,

______________ Presently using:

______________ cigarettes __________ packs a day for __________ years
______________ other form of tobacco (describe___________) for _______ years

______________ None for __________ years
Smoked ____________ packs a day for __________ years

Have you ever drunk alcoholic beverages? NO __________ YES __________

If YES,

____________ Socially: Amount ______________ Frequency ______________

____________ Daily: Amount ______________ Frequency ______________

Have you ever used “illegal” or “recreational” drugs NO __________ YES __________

If YES, describe ____

____

Have you ever used “ivy.” or “mainlined” drugs? NO __________ YES __________

If YES, describe ____

____

OCCUPATION

Check one or more:

___________ Self Employed ____________ Homemaker

___________ Employed (by others) ____________ Student

___________ Retired ____________ Unemployed

List ALL jobs you have ever performed (start with your present or most recent)

1. ____ FROM _______________ TO _______________________

2. ____ FROM _______________ TO _______________________

3. ____ FROM _______________ TO _______________________

4. ____ FROM _______________ TO _______________________

5. ____ FROM _______________ TO _______________________

6. ____ FROM _______________ TO _______________________

Have you been exposed to any toxic agent at work (dust, fumes, radiation, asbestos, etc.)? NO ______ YES ______

If YES, describe ____

____

FAMILY HISTORY

Mother: Alive _____ Age _____ Deceased _____ Age at death _____

General health _________________ Cause of death _____________________________

Father: Alive _____ Age _____ Deceased _____ Age at death _____

General health _________________ Cause of death _____________________________

Brothers & Sisters LIVING DECEASED

Age: ________ M/F ________ Health ___________ Age ________ M/F _________ Cause _________

Age: ________ M/F ________ Health ___________ Age ________ M/F _________ Cause _________

Age: ________ M/F ________ Health ___________ Age ________ M/F _________ Cause _________

Age: ________ M/F ________ Health ___________ Age ________ M/F _________ Cause _________

How many children do you have? ______________________________

Have you any children with medical problems? NO ________ YES ________ if YES, list below:

____

____

Have any of your Grandparents, Uncles, or Aunts died under the age of 65 years? NO____ YES ____

If YES, list with age and cause of death:

____ ____

____ ____

____ ____

If any of your **BLOOD** relatives have had the following conditions, check and indicate their relationship to you:

___________ Asthma ____

___________ Chronic Bronchitis ____

___________ Emphysema ____

___________ Allergies ____

___________ Diabetes ____

___________ Tuberculosis ____

___________ Heart Disease ____

___________ High Blood Pressure ____

___________ Stroke ____

___________ Cancer ____

___________ Condition like yours ____

___________ Blood clots in legs or lungs ____

___________ Bleeding problems ____

REVIEW OF SYSTEMS

SKIN

Do you have any skin lesions: NO ______________ YES ______________

If YES, describe (or give its name if possible) ____

EYES

Do you wear glasses? NO ______________ YES ______________

When your eyes were last examined? 20______

Have you noticed any difficulty with your vision? NO ______________ YES ______________

If YES, describe ____

EARS

Do you have difficulty hearing? NO ______________ YES ______________

Do you wear a hearing aid? NO ______________ YES ______________

Do you have frequent earaches? NO ______________ YES ______________

Do you have any discharge from your ears? NO ______________ YES ______________

Do you usually hear annoying buzzing or ringing in your ears? NO ______________ YES ______________

NOSE AND THROAT

Do you sneeze frequently? NO ______________ YES ______________
Is your nose continually stuffed or runny? NO ______________ YES ______________
Do you constantly feel drainage down the back of your throat? NO ______________ YES ______________
Do you have severe nosebleeds? NO ______________ YES ______________
Do you have intermittent hoarseness? NO ______________ YES ______________
Do you have persistent hoarseness? NO ______________ YES ______________
Has the sound of your voice changed? NO ______________ YES ______________
Do you often feel a choking sensation or lump in your throat? NO ______________ YES ______________

CARDIAC

Do you have a heart condition? NO ______________ YES ______________
If YES, describe ____

Do you have a chest pain with exertion? NO ______________ YES ______________
If YES, describe ____

Are you aware of an irregular heartbeat? NO ______________ YES ______________
If YES, describe ____

Do you sleep with 2 or more pillows or with a “wedge”? NO ______________ YES ______________
If YES, describe ____

Do you wake up at night with a “smothering” feeling? NO ______________ YES ______________
If YES, describe ____

Do you have swelling of your ankles? NO ______________ YES ______________
If YES, describe ____

Do you have pain or cramping in your legs when you walk? NO ______________ YES ______________
If YES, describe ____

Do you bleed easily? NO ______________ YES ______________
If YES, describe ____

GASTRO-INTESTINAL

Have you noticed any difficulty in swallowing food or water? NO ______________ YES ______________
If YES, describe ____

Do you have trouble with indigestion or heartburn? NO ______________ YES ______________
If YES, describe ____

Are you bothered with nausea or vomiting? NO ______________ YES ______________
If YES, describe ____

Has there been a recent change in your bowel habits? NO ______________ YES ______________
If YES, describe ____

Do you take OTC antacids? NO ____________ YES ____________
If YES, describe ____

Do you have a sense of reflux of stomach acid or stomach contents into your esophagus? Or into your throat? NO ____________ YES ____________

Have you had any bleeding from your rectum or with bowel movements? NO ___________ YES __________
If YES, is it bright red blood? __________ How often does it occur? _________________________

Have you noticed any black or tarry stools? NO ____________ YES ____________
If YES, how often does it occur? ____

URINARY TRACT

Do you have burning or pain when you urinate? NO ____________ YES ____________
Do you get up more than once a night to urinate? NO ____________ YES ____________
Do you have any problem starting to urinate? NO ____________ YES ____________
Have you ever noticed blood in your urine? NO ____________ YES ____________

Women: Are you past menopause? NO ____________ YES ____________
Have you noticed any lumps in your breast? NO ____________ YES ____________

MUSCULO-SKELETAL

Do you suffer from joint pain or swelling? NO ____________ YES ____________
Do your muscles/joints frequently feel stiff or sore? NO ____________ YES ____________
Do you have osteoporosis? NO ____________ YES ____________

NEUROLOGIC

Do you have frequent or severe headaches? NO ____________ YES ____________
If YES, describe ____

In the past year have you fainted or lost consciousness? NO ____________ YES ____________
If YES, describe ____

Have you had any slurring or difficulty with your speech? NO ____________ YES ____________
If YES, describe ____

Do you have numbness or tingling of your head, arms or legs? NO ____________ YES ____________
If YES, describe ____

Have you had any weakness of your hands, arms, or legs? NO ____________ YES ____________
If YES, describe ____

Do you have trouble sleeping? NO ____________ YES ____________
If YES, describe ____

Do you snore? NO ______________ YES ______________
Do you have pauses in your breathing while asleep? NO ______________ YES ______________
Do you have leg cramps or restless legs at night? NO ______________ YES ______________
Do you get sleepy in the daytime? NO ______________ YES ______________
Do you have difficulty getting up in the morning? NO ______________ YES ______________
Do you still feel tired when you get up? NO ______________ YES ______________
Do you suffer from insomnia? NO ______________ YES ______________
Do you have "sleep paralysis"? NO ______________ YES ______________
Do you have vivid dreams as you start to fall asleep? NO ______________ YES ______________

WEIGHT

What is your present weight? ___________lbs. What is your usual weight? ____________lbs.
Has your weight changed in the past year? ____________ No ____________ Gained ____________ Lost
If you have gained or lost more than 10lbs, what do you believe is the reason?

____

____

HOBBIES

Please list your hobbies:

________________________________ ___________________________ ____________________________
________________________________ ___________________________ ____________________________

TRAVEL

Please list destinations and dates for travel outside the U.S. in the past 3 years:

________________________________ ___________________________ ____________________________
________________________________ ___________________________ ____________________________

PETS

Please list all pets (including fish) and indicate if indoor or outdoor:

________________________________ ___________________________ ____________________________
________________________________ ___________________________ ____________________________

DIET

Are you on any special diet? NO ______________ YES ______________
If YES, describe ____
____

EXERCISE

Do you exercise? NO _____________ YES _____________

If YES, describe the type and duration _______________________ min and

Frequency ________________________________ times per week.

Please bring all X-Rays, medical reports and medications with you to our office. Please list any other information, which you feel may be helpful:

Completed by: ____

All information provided is complete and accurate to the best of my knowledge.

Signed ____ Date ____________________________________

Reviewed by _______________________________________ Date ____________________________________

PULMONARY CARE SPECIALISTS

CONFIDENTIAL PATIENT DATA

Patient Name ______________________________ **Birth Date** _______________ Sex: M F

Address ______________________________ SS# __________________________________

City, State, Zip _________________________ Occupation ___________________________

Preferred Pharmacy: Street, City, Zip Code ____

Please check the preferred method of contact:

- ☐ Home (____)_____________________
- ☐ Work (____)_____________________
- ☐ Cell (____)_____________________

Meaningful Use:

Race____________________________

Language__________________________

Marital Status_____________________

______I give my consent to leave a detailed message with medical information

______I DO NOT give my consent to leave a detailed message with medical information

Email address: ____

Employer Name____Phone__________________________

Employer's Address____

Primary Care Doctor____________________________________ Phone__________________________

Referring Doctor (If different) ___________________________ Phone__________________________

Emergency Contact

Name_______________________________

Relationship__________________________

Phone_______________________________

Other_______________________________

Responsible Party (if other than the patient)

Name_________________________________

Address_______________________________

City, State, Zip__________________________

Phone_________________________________

Relationship to patient____________________

Signature____

Printed Name____

PULMONARY CARE SPECIALISTS

PRIMARY INSURANCE COVERAGE

Name of Insurance Company_________________________________ HMO______PPO_______

Subscriber/Card Holder Information: Name___________________________ Birth Date__________

Policy #____Group#___________________________

Insurance Company Address____________________________________Phone number_______________

SS#_____________________Relationship to Card Holder: Self Spouse Child Other

SECONDARY INSURANCE INFORMATION

Please circle one: I have secondary insurance I do not have secondary insurance coverage

Name of Insurance Company___________________________-____________HMO______PPO_______

Subscriber/Card Holder Information: Name_______________________________Birth Date___________

Policy #____Group#___________________________

Insurance Company Address____________________________________Phone number_______________

SS#_____________________Relationship to Card Holder: Self Spouse Child Other

BENEFIT ASSIGNMENT AND MEDICAL RECORD RELEASE

I authorize my insurance benefits to be made directly to the treating physician for services rendered and all future claims for services rendered. I attest that the above insurance information is accurate and that I am an eligible member. I also authorize the release of all information necessary for the purpose of payment for services rendered for current and future claims. I acknowledge that I have read the financial policy of the practice, I understand the policy, and agree to give consent for treatment.

SIGNATURE OF PATIENT OR GUARDIAN____

PRINTED NAME____**DATE**_________________

FINANCIAL POLICY

CASH POLICY - Pay for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE - We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS - We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

NONCOVERED SERVICES - Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES - This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

MISSED APPOINTMENTS - In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made on my behalf to the health care professional providing any services furnished me. I authorize any holder of medical information about me to release to the health care professional's billing staff any information needed to determine these benefits or the benefits payable to related services.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to the health care professional providing health services to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I understand that my insurance is a contract between myself and my insurance company. The healthcare professionals' billing staff will file my claim and will work to resolve any problems obtaining payment from

my insurance company, but ultimately it is my responsibility to contact my insurance company to resolve any problems.

The patient is ultimately responsible for all professional fees.
I have read, understood, and agree to the above financial policy.

Patient or guarantor signature_______________________________

Date________________________

PULMONARY CARE SPECIALISTS, PA

James P. Loftin, M.D. **Melissa L. Tompkins, M.D.**

RELEASE OF MEDICAL RECORDS

I, ____

Date of Birth_______________________authorize

Doctor/practice name_________________________________

Address: ____

____

To release my medical records to:

James P. Loftin, MD
Melissa L. Tompkins, MD

4333 N. Josey Lane
Suite 207
Carrollton, TX 75010

Phone no: 972-394-2971
Fax number 972-492-1261

Please include the following:

_________ labs _______ radiology tests

_________ office notes _______ spiro/pft

_________ other _________________________________

Patient's Signature ______________________________

Printed Name: ______________________________

Date: _________________ Witness: __________________

I understand that I have the right to revoke this authorization, in writing, at any time, by sending written notification to the practice. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

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

____

____

____

____

I give my permission to speak with the following persons regarding my healthcare and any financial issues related to my care:

Name____

Phone number__________________________________Relationship ______________________

Name____

Phone number__________________________________Relationship ______________________

Name____

Phone number__________________________________Relationship ________________________

Patient Name: ____ Patient Date of Birth_______________

(Please Print Name)

SIGNATURES:

Patient/Legal Representative: ____ *Date*: _________________

If Legal Representative, relationship to Patient: ____

Witness (optional): ____Date: _______________

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