

SMMG Pulmonary, Critical Care, and Sleep Center

Have you been treated at any Saint Mary's Medical Group Clinics in the past 3 years: (Urgent Care, Primary Care, Specialist) Yes No

PATIENT INFORMATION					
PATIENT NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER		DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
MAILING ADDRESS		APT/SUITE#	CITY	STATE	ZIP
PHYSICAL ADDRESS (IF DIFFERENT)		APT/SUITE#	CITY	STATE	ZIP
RACE	LANGUAGE	ETHNICITY		MARITAL STATUS	
HOME PHONE	CELL PHONE	EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN	PHONE NUMBER	PREFERRED CONTACT NUMBER WHERE WE MAY LEAVE MESSAGES ABOUT YOUR HEALTHCARE? <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone			
EMPLOYER		WORK PHONE	HOW WOULD YOU LIKE TO BE NOTIFIED OF FUTURE APPOINTMENTS? <input type="checkbox"/> TEXT <input type="checkbox"/> PHONE CALL <input type="checkbox"/> BOTH		
EMPLOYER ADDRESS		SUITE#	CITY	STATE	ZIP
EMERGENCY CONTACT (first name last name)		PHONE	DATE OF BIRTH	RELATIONSHIP	

How did you hear about us? Billboard Radio Insurance Friend/ Friend Drove By Other _____
 Referred By Physician _____ phone _____

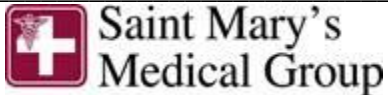
INSURANCE INFORMATION				
PRIMARY INSURANCE				
POLICY HOLDER NAME	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	
SECONDARY INSURANCE				
POLICY HOLDER NAME	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	
Medicare Patients only: Are you entitled to Medicare because <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> ESRD Is someone else or another entity responsible for the billing claim from this visit? <input type="checkbox"/> YES <input type="checkbox"/> NO WHO _____				

Are you here because of an injury? Yes No DATE OF INJURY __/__/____ Work Auto Other:

PARENT/GUARDIAN INFORMATION (please fill out the section below for any child under the age 18)				
NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/> Guarantor (person financially responsible)	CELL PHONE	HOME PHONE	MARITAL STATUS	
NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/> Guarantor (person financially responsible)	CELL PHONE	HOME PHONE	MARITAL STATUS	

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

Patient/Guardian Signature _____ **Date** _____



Patient Demographics

PATIENT LABEL

Do you have an Advance Directive?
 None Living Will DNR POLST Durable Power of Attorney

SMMG Pulmonary, Critical Care and Sleep Center

Medication/Dose/Frequency	Medication/Dose/Frequency	Pharmacy

Allergies & Reactions (please list any allergies or reactions to medication or food below)			
Medication	Type of Reaction	Food	Type of Reaction

Past Medical History (please indicate if you have ever experienced any of the following conditions)			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Angina (chest pain)	<input type="checkbox"/> COPD	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> Irregular heart rhythm	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer: Type	<input type="checkbox"/> Esophageal reflux	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tinnitus (ringing in ear)
<input type="checkbox"/> Chronic Blood Thinner Use	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Migraines	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Chronic Hepatitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Obesity	<input type="checkbox"/> Episodes of passing out
Please list other conditions not mentioned above:			

Surgical History (please list any surgeries and date)	Hospitalization (please list any major hospitalizations & year)

Family History (please list any family history of medical problems)	

Social History								
	Yes	No	Former	Type	Amount Daily	Amount Weekly	Years Used	Date/Year Quit
Tobacco Use								
Alcohol								
Caffeine								



Patient Medical History

PATIENT LABEL

Primary Care Health Maintenance					
	Date of Last	Where		Date of Last	Where
Lipid Panel			Mammogram		
FIT/Hemocult			DEXA Scan		
Colonoscopy			EKG		
Sigmoidscopy			Foot Exam		
Influenza Vaccine			Eye Exam		
Pneumococcal Vaccine			GYN Exam (Pap/Breast)		
Tetanus Vaccine			PSA/Rectal Exam		
Annual Wellness (Medicare)					

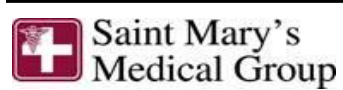
Review of Systems (Place an "X" in the box indicating YES to all that apply)					
	GENERAL		GENITOURINARY		
	Frequent colds/sore throats		Pain with urination		Frequent bleeding
	Hay fever/sinus problems		Difficulty with urination		ENDOCRINE
	Trouble swallowing		Blood in urine		Hair loss
	Weight gain/loss		Frequent urination		Hot flashes
	Visual problems		Urinary tract infections		Constant thirst
	Ringing in the ears		Erectile dysfunction		Lethargy
	Fatigue		DIGESTIVE		Heat/cold intolerance
	Fevers		Frequent heartburn		Sweating
	Loss of Hearing		Diarrhea		Hair loss
	CARDIOPULMONARY		Constipation		SLEEP
	Shortness of breath		Nausea		Difficulty falling asleep
	Difficulty lying flat		Difficulty swallowing		Difficulty staying asleep
	Chest pain		Dark stools		Snoring
	Dizziness		Blood in stool		Abnormal dreams
	Irregular Heartbeat		Frequent vomiting		Stop breathing at night
	Cough at night		Jaundice		Morning headaches
	Palpitations		MUSCULOSKELTAL		NEURO/PSYCHIATRIC
	Leg swelling		Swollen joints		Anxiety
	Difficulty sleeping		Painful joints		Tremor
	Lightheadedness		Back pain		Abnormal fears
	High blood pressure		Limited motion		Passing out
	Non-healing ulcers		Varicose veins		Forgetfulness
	Wheezing		Leg cramps		Balance problems
	Heart murmur		BLOOD/COAGULATION		Seizures
	Leg pain with walking		Frequent bruising		

I understand that it is my responsibility to keep all follow-up appointments, take medications as directed, and complete laboratory tests ordered in a timely fashion as directed by my provider. If I fail to follow these directives as instructed by my provider, I assume responsibility for the adverse repercussions that this may have on my health.

Patient/Guardian Name (please print) _____ Date ____ \ ____ \ ____

Patient/Guardian Signature _____ Date ____ \ ____ \ ____

Provider Signature _____ Date ____ \ ____ \ ____



SMMG Pulmonary, Critical Care, and Sleep Center

PATIENT DOCUMENTS RECEIVED:

- Notice of Privacy Practices _____ (initial)
- Patient Financial Policy _____ (initial)
- Patient Portal Access and Use Agreement _____ (initial)

Email Address: _____

TREATMENT: I consent to and authorize Saint Mary’s Medical Group and Saint Mary’s Urgent Care Providers to examine and provide treatment.

RELEASE OF INFORMATION

- I authorize a copy of my record to be sent to my family provider or provider of referral following my appointment. **Preservation of Records Notice:** The Medical Group is authorized to dispose of patient’s medical record after the 10th anniversary of the date the patient was last treated. For minor patients (less than 18 years of age) the medical group is authorized to dispose of patient’s medical records after patient’s 23rd birthday for those records which have been retained for at least 5 years or for any longer period provided by federal law.
- I authorize Saint Mary’s Medical Group and Saint Mary’s Urgent Care to speak to the named person (s) listed below regarding my medical condition(s) and care. Please be aware that we will not be able to speak to anyone other than the patient unless named below.

Name _____ Relationship _____

Name _____ Relationship _____

PRESCRIPTIONS: I authorize Saint Mary’s Medical Group and Saint Mary’s Urgent Care and its designees to view my pharmaceutical history from external sources. Our practice uses Surescripts for this purpose.

EMPLOYEE OR PROVIDER EXPOSURE TO BLOOD AND BODY FLUIDS: Patient understands that in the event an employee or provider is exposed to patient’s blood or body fluids, a blood sample for HIV (AIDS), Hepatitis B and Hepatitis C antibodies will be obtained. Patient understands that the patient will be notified of testing. Patient understands that the results are confidential and will not be released to a third party without patient’s permission except as permitted or required by law

INTERPRETER INFORMATION: If the patient speaks a language other than English or is communicatively disabled, I have accurately and completely read the forgoing documents to _____ (name of patient/person legally authorized to give consent) in the patient’s or patient’s representative primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

(SMMG Representative Name)

(SMMG Representative Signature)

(Cyracom ID number or Signature of onsite Interpreter)

(Date)

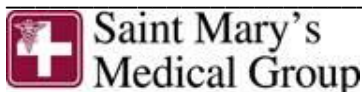
(Time)

AM / PM

By signing below, I agree to abide by the terms and conditions outlined above including the patient documents received.

Patient/Representative Name (Please Print) _____ Date ____________

Patient/Representative Signature _____ Date ____________



Patient Consent & Acknowledgement

PATIENT LABEL

**CONSENT FOR TREATMENT OF MINOR CHILD
PARENT OR LEGAL GUARDIAN NOT PRESENT**

In the event that the parent(s) or legal guardian(s) of the patient named below is/are not available at the time of service and at the sole discretion of the Provider of Care and/or Management, this form may be used to document authorization for treatment received by phone if patient is accompanied by an authorized person 18 years or older.

Parent or person having legal custody/legal guardianship authorizes:

_____ *name of person accompanying patient* _____ *date of birth*

to bring _____ *patient's name* _____ *patients date of birth*

I authorize _____ all the information contained in this document.

We spoke with _____ (parent or legal guardian name)

(date of birth) _____

Identification on file _____ **(indicate relationship)**

at (_____) _____ - _____ **(number called)** at _____ am / pm **(circle one)**

We further acknowledge that we obtained verification of the identity of the patient's parent or legal guardian using established standard operating procedure.

Verified all information as above. Verbal consent obtained

Staff Member #1: Print Name _____

Signature _____ Date _____

Staff Member #2: Print Name _____

Signature _____ Date _____