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Please fill out the enclosed paperwork and bring with you to your appointment.

**If you do not have insurance,
please call our office prior to
your appointment to set up
payment arrangements.**

Thank you.

LYNCHBURG PULMONARY
ASSOCIATES, Inc.

2011 Tate Springs Road
Lynchburg, Virginia 24501

Tel: 434-947-3963
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www.lynchburgpulmonary.com

Lynchburg Pulmonary Associates, Inc.

Health History Questionnaire (fill out both pages please)

Name: _____

Primary Doctor: _____

Other Doctors: _____

REASON FOR TODAY'S VISIT: _____

Medication Allergies: _____

Year of last pneumonia vaccine (pneumovax): _____ or Never

Do you get influenza (flu) vaccines? Yes No

Have you ever had whooping cough (pertussis)? Yes No

Have you ever been exposed to tuberculosis (TB)? Yes No

List Your Medical Problems & Surgeries (write on back if necessary)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Your Family History:

Father Alive? Yes No Medical Problems? _____

Mother Alive? Yes No Medical Problems? _____

Number of Brothers: _____ Medical Problems? _____

Number of Sisters: _____ Medical Problems? _____

Number of Children: _____ Medical Problems? _____

Social History:

Marital Status: Single Married Widowed Divorced

Employment Status:

Working now

Retired

Disabled

Not working

List jobs you have done:

1.	_____
2.	_____
3.	_____
4.	_____

Have you ever smoked tobacco? Yes No Are you still smoking? Yes No

How many packs each day? _____ For how many years have you smoked? _____

Do you drink alcohol? Yes No How many servings each week? _____

Have you used any recreational drugs? Yes No

How many servings of Caffeine do you drink each day? _____

Do you have a Living Will or Power of Attorney? Yes No

Do you have a Durable Do Not Resuscitate? Yes No

Exposure History:

Any animals at home: Dogs Cats Birds Farm Animals Other

Any problems with water leakage, dampness, or mold at home? Yes No

Have you been exposed to asbestos or sand dust? Yes No

Have you been exposed to radiation or strong fumes? Yes No

List other unusual exposures: _____



2011 Tate Springs Road, Lynchburg, VA 24501

PATIENT REGISTRATION FORM

Please Fill Out Completely:

PATIENT INFORMATION

Patient Name: _____

Patient Mailing Address: _____

Physical Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Work Phone Number: _____

Marital Status: Single Married Separated/Divorced Widowed

Sex: Male Female

Race: _____

Spouses Name: _____

Spouses Date of Birth: _____ Spouses Social Security Number: _____

Spouses Employer: _____ Spouses Occupation: _____

Spouses Employers Phone Number: _____

Emergency Contact (Not in same house):

Name: _____ Relationship: _____

Address: _____

Phone: (H) _____ (W) _____

FINANCIALLY RESPONSIBLE PARTY:

Name: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Employer Address (Physical): _____

Employer Phone Number: _____

Relationship to Insured: _____

(Husband, Wife, Son, Daughter, Self)

INSURANCE INFORMATION

Primary Insurance:

Secondary Insurance:

Insurance Company: _____

Insurance Company: _____

Address: _____

Address: _____

Subscriber Name: _____

Subscriber Name: _____

ID#: _____

ID#: _____

Group or Policy #: _____

Group or Policy #: _____

Subscriber Employer: _____

Subscriber Employer: _____

RELEASE OF INFORMATION

Practice Philosophy on Patient Privacy

The practice recognizes the importance of patient privacy. As such, it is the policy of this Practice to treat all medical information as confidential and absent extraordinary or emergency circumstances, the Practice will not disclose a patient's medical information without appropriate patient consent.

Before consenting to the release of medical information, each patient has the right to review the written Notice of Privacy Policy of this Practice, which gives a more complete description of the Practice's policies on the use and disclosure of patients' medical information. Each patient may obtain a copy of such Notice upon request. The Practice reserves the right to change its Notice of Privacy Policy and all patients have the right to receive an amended copy of the Notice upon request.

Also, each patient has the right to request in writing that this Practice restrict how protected and private medical information is used or disclosed to carry out treatment, payment, or other health care operations. Please note that this Practice is not required to agree to such requested restrictions, but if it does, the restriction will be binding upon the Practice. Additionally, the Practice may refuse to treat any patient who refuses to consent to the use and disclosure of medical information for treatment, payment, or other health care operation purposes.

Patient Consent for Use and Disclosure of Medical Information to Carry Out Treatment, Payment and Health Care Operations

I consent to the release of information regarding services rendered by the Practice to my insurance company, or any governmental payor of the medical expenses as listed above, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of medical information to my family physician and other treating physicians, as well as to any physicians to whom the Practice may refer me for purposes of further treatment. I also consent to the use and/or release of medical information about me for purposes of health care operations, including quality assurance activities or other activities to review the Practice's treatment and services and to evaluate the performance of the staff in caring for me. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person(s) that I have listed above as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including but not limited to, electronic mail, ("Email") and facsimile.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has taken action in reliance upon my consent.

Patient/Parent/Guardian Signature: _____

Date: _____

PAYMENT AGREEMENT:

Regardless of insurance benefits, or the designation of some other responsible party above, I understand that I am financially responsible for the fees.

If I am covered by Medicare, I understand that I am provided specific written notice, in advance, that Medicare is not likely to cover a particular visit or procedure, I will be responsible to pay for that procedure or visit if I agree to proceed with that procedure or visit. Although the Practice will take reasonable steps to obtain reimbursement from the insurance company or the persons listed above as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. **I understand and agree that I will be responsible for any and all Collection Agency and or Attorney fees should my delinquent account be turned over for collections.**

At the time of the visit, I understand it is my responsibility to obtain a current referral (if required) and pay any deductibles, co-payments, and/or coinsurance not covered by the insurance plan or a governmental program. Further, I authorize the Practice to file claims on my behalf for covered services and assign all insurance or other payor benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original.

I have read and I understand this document:

Patient/Parent/Guardian Signature: _____

Date: _____