# K.C. PULMONARY ASSOCIATES

PULMONDARY DISEASES, CRITICAL CARE & SLEEP MEDICINE

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PATIENT'S NAME: _____

ADDRESS _____

CITY, STATE, ZIP CODE: _____

TELEPHONE: HOME _____ CELL: _____ WORK: _____
BIRTH DATE: _____AGE: _____SEX: _____SOCIAL SECURUTY #_____
MARITAL STATUS: S M D W
PATIENT EMPLOYEDBY: _____OCCUPATION: _____
BUSINESS ADDRESS _____

PERSON WHO REFERRED YOU_____

Name of PHYSICIAN: _____

PHONE _____ ADDRESS: _____

PRIMARY INSURANCE _____EFFECTIVE DATE_____

POLICY # _____GROUP# _____

PRIMARY INSURED'S NAME_____ BIRTH DATE: _____

RELATIONSHIP TO INSURED_____

SECONDARYINSURANCE_____EFFECTIVEDATE_____

POLICY#_____GROUP#_____

SECONDARY INSURED'S NAME: _____BIRTH DATE:_____

**ASSINGMENT AND RELEASE**

I authorize KC Pulmonary Associates to release information about me concerning advice; care and treatmentprovidedmetomyinsurancecompany forthepurposeoffilinganinsuranceclaim. Iauthorize paymentof insurancebenefitstobemadedirectlytoKCPulmonaryAssociates. IunderstandthatI am financiallyresponsibleforpaymentofanydeductible,co-insuranceoranybalancenotcoveredbymy insurance.

Furthermore,IauthorizeKCPulmonaryAssociatestoreleasemyrecordstomyprimaryphysicianfor coordination ofmy care unless specified otherwise.

DATE: _____ SIGNATURE_____

8919 Parallel Parkway, Suite 203 Kansas City, KS 66112 (913) 268-5400 Fax (913) 268-5410

# PATIENT CONTACT INFORMATION

The HIPAA privacy rule provides the patient with the right to request confidential communication or that communication of Protected Health Information is made by alternative means, such as sending to the correspondence to the individual's office instead of to the individual's· home.

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER**
**CHECK ALL THAT APPLY:**

Home telephone: _____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only

Cell Phone_____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only

Work telephone: _____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only·

Written communication

- ○ OK to mail to Home Address: _____
- ○ OK to mail to my Work/Office Address_____
- ○ OK to Fax to this number_____
- ○ OK to Email to this Address_____

Other

- ○ OK to Share the information with the Following person (s):
- ○ _____
- ○ _____

Person (not living with you) to contact if unable to reach you directly:

Name:_____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

**CONSULTATION QUESTIONAIRE**

**Name: _____**

**REFERING PHYSICIAN: _____**

**REASON FOR CONSULTATION:**

**_____**

(Short of air, chest pain, abnormal CT or chest X-ray)

**COUGH**

Duration of cough_____

Association of cough with food or drinks_____

Associated fever or chills_____

Any recent coughing of blood_____

Any un-intentional weight loss_____

Any new medicine that has increased cough_____

**TOBACCO USE**

How many years of tobacco use? _____

How many packs per day? _____

When did you quit smoking? _____

Have you tried any smoking cessation efforts? _____

**SHORTNESS OF BREATH**

How long is the duration? _____

Associated chest pain_____

Associated wheezing_____

Precipitating factors_____

Is it worse at night? _____

**OCCUPATIONAL**

Exposure to second hand tobacco_____

Exposure is Asbestos or other chemicals, if so the duration of exposure_____

Exposure to farm dust_____

Any pets (birds, cats...etc.) _____

Any exposure to mold_____

Any exposure to wooded areas_____

**MISCELLANEOUS**

Any history of blood clots in lungs or legs_____

Any history of previous lung surgery_____

Any history of chemotherapy_____

Any history of Prednisone for longer than 2 weeks_____

Any use of oxygen during day or night_____

**PRESENT MEDICAL CONDITIONS**

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____
6.) _____

**PAST SURGERY**

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____
6.) _____

**LIST OF MEDICATIONS**

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____
6.) _____

**Drug Allergies:** _____