Panama City Pulmonary, LLC
2426 Jenks Avenue, Panama City, FL 32405
(850) 763-9459 (850) 763-9462 Fax
Angel A. Núñez, M.D., F.C.C.P.,D,ABSM

PATIENT INFORMATION FORM

Date________________________

Name__________________________________Home Phone ______________ Work Phone__________________

Cell Phone __________________________E-Mail Address____

Home Address______________________________________City__________________St______Zip________

Social Security #____________________________Date of Birth _____________________ Sex (M) (F)

Employer____Address____________________________________

Marital Status (M) (S) (D) (W) Spouse's Name________________________________

Person to contact in case of an
emergency____Phone________________________

Who referred you to this
office:____Address:____

Phone:_________________________

Who is you primary care
physician:____Address____

Phone: _________________________

INSURANCE INFORMATION
(Present Insurance Cards to Receptionist)

Primary Insurance____

Address ______________________________________City____________________State______Zip_________

Telephone Number__________________________Insurance ID#__________________________________

Date of Birth of Policyholder__________________Social Security # of Policyholder_________________________

Secondary Insurance____

Address _________________________________City____________________State______Zip_________

Telephone Number__________________________Insurance ID#__________________________________

Date of Birth of Policyholder_________________Social Security # of Policyholder_____________________

Do you have a Living Will? (Yes) (No)

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of any professional services rendered. If, for any reason, the account should become delinquent, I agree to pay any billing charges, collection costs, and reasonable legal fees. I have read all the information above and certify this information is true and correct to the best of my knowledge.

Signature of Responsible Party_____________________________________Date______________________

Patient Name

Name:	DOB:	Age:	Date:	Requesting/Primary Physician:

Please help us find out about you by filling out the "Patient" side of this form on pages 1-6. If you don't know the answer to one of the questions, ask your bed partner if he/she can answer it for you.

Please leave "Clinician" side blank.

SLEEP PATIENT

Why are you here to see a sleep specialist?

If you are already on CPAP go to page 2

Do you snore?

☐ Yes ☐ No ☐ Don't know

If yes, is it loud?

☐ Yes ☐ No ☐ Don't know

In which position do you snore?

☐ Back ☐ All ☐ Don't know

Does it disturb anyone?

☐ Yes ☐ No ☐ Don't know

What is your collar size?______________

Has anyone ever noticed if you stop breathing in your sleep?

☐ Yes ☐ No

Do you gasp or choke while you sleep?

☐ Yes ☐ No

Do you suffer from either of the following in the morning?

☐ Dry mouth ☐ Headache

Do you feel sleepy during the daytime?

☐ Yes ☐ No ☐ Don't know

How many days per week? ______________

When did it start? ______________

Is it worsening? ______________

☐ Yes ☐ No ☐ Don't know

Please continue on page 3.

Office Procedures for Today's Visit:

	Ordered			Completed
☐	Full PFTs	☐ ATS Citeria		☐
☐	Pre/Post Spriometry			☐
☐	6 MWT with O2 Titration			☐
☐	SpO2			☐
☐	Inhaler Training			☐
☐	PA/LA CXR			☐
☐	CT Chest			☐
☐	Influenz vaccination	☐ H1N1	☐	
☐	INR Check			☐
☐	Other			

CLINICIAN

CC

Patient Name

SLEEP PATIENT | **CLINICIAN**

Do wear CPAP?

☐ Yes ☐ No If no please exlalain why: ____

How many nights per week? ____

How many hours a night? ____

Have you been told you snore while wearing CPAP

☐ Yes ☐ No

Any problems with:

Dry throat?

☐ Yes ☐ No

Morning headache:

☐ Yes ☐ No

Bloating and gas in the morning?

☐ Yes ☐ No

Nasal congestion

☐ Yes ☐ No

Do you take daytime stimulants?

☐ Yes ☐ No If so what kind? ____

Do you take sleeping pills ?

☐ Yes ☐ No If so what kind? ____

What kind of mask do you use?

Nasal pillow ____

Nasal mask ____

Full face mask ____

When did you last get a new mask? ____

HPI

Please continue on next page.

Patient Name

PATIENT	CLINICIAN

Have you ever had a close call,drowsiness or accident when driving because of sleepiness?

☐ Yes ☐ No ☐ Don't know

Do you suffer from memory problems?

☐ Yes ☐ No

Do you find it difficult to focus or concentrate?

☐ Yes ☐ No

Do you take any daytime naps?

☐ Yes ☐ No

How many per week?

How long, on average, do they last?

Are the naps refreshing?

☐ Yes ☐ No

Are you irritable lately?

☐ Yes ☐ No

Have you been feeling depressed or overly anxious?

☐ Yes ☐ No

Have you been told by a health care professional that you may suffer from depression?

☐ Yes ☐ No

Rate the severity of your sleepiness on a scale of 1 to 10. (1 being no sleepiness and 10 being very severe sleepiness)_____

Do you ever experience restlessness or discomfort in your legs?

☐ Yes ☐ No When?

What do you do to relieve it?

How often does it occur? ____________

Does it interfere with sleep? ____________

☐ Yes ☐ No

Do you move or kick your legs while sleeping?

☐ Yes ☐ No

Do you take medications for restless legs?

☐ Yes ☐ No If so which medication ?____________

Have you ever felt the sudden loss of strength

(arms, legs) in response to some emotional experience?

☐ Yes ☐ No

Have you ever felt paralyzed when you first wake up or falling asleep?

☐ Yes ☐ No

Do you ever dream while you are falling asleep or napping?

☐ Yes ☐ No

Do you ever accidentally urinate in bed?

☐ Yes ☐ No

Do you walk or talk in your sleep?

☐ Yes ☐ No

Do you have nightmares?

☐ Yes ☐ No

Tell us about your sleep schedule:

What is your bedtime? Start

How long does it take you to fall asleep? ____________

When do you wake up? ____________

Do you feel refreshed? ____________

When do you wake up on weekends & days off?

____________Feel better if sleep longer?____________

Patient Name

Do you wake up in the middle of the night?

- ☐ Yes ☐ No **If yes do you look at the clock** ________

How many times per night? ________

Do you fall asleep again easily?

- ☐ Yes ☐ No

How many times a night do you go the bathroom?

Do you lie in bed not being able to sleep?

- ☐ Yes ☐ No

Do you watch TV in bed ?

- ☐ Yes ☐ No

When sleeping away from home do you sleep better or worse?

- ☐ Better ☐ Worse

Tell us about your daytime schedule:

What is your occupation and work hours? ________

Are you a commercial driver? ___Yes ___ No

How likely are you to doze off or fall asleep in the following situations?

Please use the following scale:

0 Would never doze

1 Slight chance of dozing

2 Moderate chance of dozing

3 High chance of dozing

___ **Sitting and reading**

___ **Watching television**

___ **Sitting inactive in a public place**

___ **While a passenger in a car without a break**

___ **Laying down to rest in the afternoon when circumstances permit**

___ **Sitting and talking to someone**

___ **Sitting quietly after a lunch without alcohol**

___ **In a car, while stopped in traffic for a few min.**

Has your weight changed ? ___ Increased ____ Decreased

Have you ever had any operations?

1 ________

2 ________

3 ________

4 ________

PAST FAMILY SOCIAL HISTORY

Epworth Score: ________

Past Surg Hx

Patient Name

PMH

Do you have high blood pressure?

☐ Yes ☐ No

Have you ever had a stroke or heart attack?

☐ Yes ☐ No If yes when ______

Do you suffer from angina?

☐ Yes ☐ No

Do you have a cough?

☐ Yes ☐ No

Do you get short of breath?

☐ Yes ☐ No

Have you ever been diagnosed with Asthma or COPD?

What other medical problems do you have?

______

______

List your current medications?

1 ______
2 ______
3 ______
4 ______
5

Medications:

Check if any close family member (parents, brothers and sisters, children) have:

☐ Heart Problems
☐ High Blood Pressure
☐ Diabetes
☐ Cancer
☐ Heartburn
☐ Obstructive Sleep Apnea

Family Hx

Are there any other health problems in your family?

______

Do you have any allergies?

☐ Yes ☐ No

PATIENT | **CLINICIAN**

Marital Status **S** **M** **W** **D**

Do you currently smoke?

☐ Yes ☐ No If yes how long_____How much_____

Social Hx

Have you ever smoked?

☐ Yes ☐ No If yes how long_____How much_____

Do you drink alcoholic beverages?

☐ Yes ☐ No

Do you currently use recreational drugs?

☐ Yes ☐ No

Do you drink:

How much per day

☐ coffee ______
☐ tea ______
☐ soda ______
☐ energy drinks ______

With whom do you live? ______

What is your occupation? ______

What are your leisure activities? ______

______

What is your education level? ______

Patient Name

PATIENT ***Please circle any symptom you have, so we can find out more about it:***	**REVIEW OF SYMPTOMS**
Lack of energy; daytime sleepiness; trouble sleeping; snoring; loss of appetite; weight changes; fevers	Constitutional
Eye problems, such as double or blurred vision; glaucoma; cataracts	HEENT
Hearing problems; buzzing or ringing in ears	
Allergies; hay fever	
Sinus problems	
Blood pressure or heart problems	Cardiac
Asthma; tuberculosis	Pulmonary
Stomach problems; heartburn; indigestion; change in bowl habits	Digestive
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems: Frequency; infections; stones; bladder	Urinary
Men: Prostate problems; night-time urination	
Women: Abnormal menstrual periods; could you be pregnant?	
Joint pains swelling or redness; arthritis; back pain	Musculoskeletal
Muscle aches or tenderness; gout	
Rash, itching or other skin problems	Dermatological
Women: breast lumps; recent mammogram, pap smear and/or pelvic exam	Female Reproductive
Paralysis (even temporary); stroke; numbness; loss of balance	Neurological
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	Psychiatric
Suicide attempts	
Thyroid disorder; diabetes; excess thirst; hunger or urination	Endocrinology
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	Hematological

The above history information was obtained by or personally reviewed by me. I agree with or have amended it's findings

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CONSENT OF DISCLOSURE

(For the usage and/or disclosure of protected health information)

I hereby give consent to Panama City Pulmonary, LLC to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations.

You may cancel this at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purpose of treatment, payment, or healthcare operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted privacy policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our posted privacy policy before you sign this consent.

We reserve the right to amend the terms of our posted privacy policy. You may obtain a copy of the current policy by calling Patty at 850-763-9459.

PRINT NAME OF PATIENT:____

SIGNATURE:______________________________________Date_____________

If you are signing as the patient's representative

Print your name____
Relationship____

Address for cancellation: Your cancellation will be effective upon receipt at the following address: Panama City Pulmonary, LLC
2426 Jenks Ave. Panama City, Florida 32405

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(850) 763-9459 (850) 763-9462 fax
Dr. Angel N`uñez, M.D.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I,____,understand Panama City Pulmonary LLC, is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment or health care operations.
I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Panama City Pulmonary, LLC, or any other individual listed below to disclose my protected health information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth above.

IMPORTANT: This notice describes your rights as a patient and how your medical information may be used and disclosed. Please review this notice carefully and acknowledge receipt by your signature on the attached page at the end of this notice.

DESCRIPTION OF THE INFORMATION TO BE USED OR DISCLOSED (check all that apply):

( ) The patient's entire medical record
( ) The patient's demographic information
( ) Medical data/information

Please list any conditions not to be released, if any:____________________________________

Please list the name(s) to whom we can disclose the patient's protected health information:

This authorization is to be used for our own use, and Panama City Pulmonary, LLC will not condition treatment or payment on this authorization. Moreover, the patient has the right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Panama City Pulmonary, LLC must receive the revocation in writing. The revocation must include:

The patient's name, address, and patient number, if applicable.
The effective date of this authorization, and the recipients of the protected health information according to this authorization
The patient's desire to revoke this authorization, and the date of the revocation and the patient's signature

Panama City Pulmonary, LLC will accept written revocations of this authorization via Certified U.S. Mail or fax to 850-763-9462.
All revocations must be sent to Panama City Pulmonary, LLC to the attention of the Privacy Office, P. Kinard, and are not effective until received by the Privacy Officer.
This authorization shall not expire as long as you are a patient at this office.

I fully understand and accept the terms of this authorization.

____________________________________ ________________________
Patient's Signature Date

FOR OFFICE USE ONLY
Authorization added to the patient's medical record on:____________________ By:____________________________

TREATMENT AND PAYMENT AGREEMENT

Panama City Pulmonary
2426 Jenks Ave.
Panama City, FL 32405
Phone (850) 763-9459 Fax (850) 763-9462

1. **Treatment Consent and Authorization:** I consent and authorize Panama City Pulmonary to examine me and perform all treatments for this and all following visits, including, without limitation, prescribed medications, performance of diagnostic procedures and laboratory tests as deemed necessary or advisable by the attending physician. This consent and authorization is given in advance of any specific diagnosis or treatment and is continuing until revoked in writing.
2. **Insurance Plan Benefits:** Panama City Pulmonary participates with multiple insurance plans. Each insurance plan has different benefit packages and regulations. I understand, acknowledge and agree that it is my responsibility to be familiar with my insurance benefits and to advise Panama City Pulmonary's staff regarding my insurance coverage. **I understand, acknowledge and agree that I am fully responsible for all charges, including, without limitation, laboratory tests, that are not covered by my insurance policy.**
3. **Payment Agreement and Financial Patient Policies:** Panama City Pulmonary will file the insurance claim(s) with my insurance carrier for services provided to me. I understand, acknowledge, and agree that Panama City Pulmonary must collect my co-payments and deductibles at the time the service is rendered. I am required to present my insurance card at the time of visit. Without a current insurance card, Panama City Pulmonary will not be able to file my claims appropriately and I will be responsible for the payment of all charges. If my insurance coverage changes, I agree to notify Panama City Pulmonary at the time of my visit. Panama City Pulmonary may not be able to re-file claims, and I would be responsible for full payment.
4. **Prescription Refills:** It is our policy that you should take responsibility to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, walk-in, after hours or phone call refill requests.
5. **Patient Fees for Other Services:** Panama City Pulmonary has specific charges for missing appointments without a 24-hour advance notice, filling our medical forms, copying medical records when they are not going to a physician that either referred you to us or that we referred you to, returned checks, prescription refills that are requested over the phone and also for family and patient meetings with the physician outside of your scheduled follow-up appointment. These charges are the patient's responsibility and will not be billed to any insurance company. There will be a 5-10 business day turnaround for all records requests and medical forms.

   Please initial next to each item that you understand, acknowledge and agree that you will be responsible for these charges should they be necessary.

Initial	Description of Service	Description of Billing	Cost of Service to patient
	No-show fee for office visit	Appointment missed without 24-hour advance notice	$25.00 per occurrence
	Returned check fee	Check returned unpaid by bank	$30 per occurrence/must pay using cash or credit for future visits
	Medical Records Medical forms filled out	Medical Records Copy 1-3 pages 4or more pages	$1.00 per page up to 25 pages, .50 each thereafter. $15.00 per form $25.00 per form

Signature of Patient :____ Date:____________________