

Patient Demographic & Insurance Information

Basic Patient Information

Patient's Social Security Number: _____

Name of Patient

First

Middle

Last

Birth Date

Gender

F

M

Mailing Address

City

State

Zip

Home Phone ()

Cell Phone ()

Work ()

Which Physician are you seeing today?

Physician:

PEDRO LOPEZ, MD

JEANNE LIPSCOMB, MD

MOHAMMAD AZAM, MD

NARAYAN KRISHNAMURTHY, MD

F. FABIAN SALINAS, MD

KM DINESH CHANDRA, MD

Please present your insurance card to the front desk receptionist when returning this form

Insurance Coverage - Primary

Name of Insurance

Policy or Contract Number

Effective Date: (if applicable)

Group Number

Primary Care Physician

Name of Insured

Patient's Relationship to Insured?

Self

Child

Spouse

Guardian

Other

Birth Date

Retire Date (if applicable)

Gender

F

M

Phone ()

Name of Insured's Employer

Address of Insurance Holder

(If different than Patient Address)

City

State

Zip

I hereby authorize all insurance payments, including Medicare, to be made directly to Tuscaloosa Lung, Critical Care & Sleep for medical services rendered. I authorize the release of any medical information deemed necessary in the processing of a claim. I understand that I am responsible for any and all charges, regardless of insurance coverage. I also agree that failure to make payment when requested is the basis for legal action, and agree to pay all costs of collections, including reasonable collection fees. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications. I authorize the physicians to perform any procedures which may be deemed necessary in the judgement of the attending physician in the diagnosis and treatment of the patient's condition.

Date

Signature

Please complete additional information on the back of this form

Insurance Coverage - Secondary

Name of Insurance _____

Policy or Contract Number _____

Effective Date: _____

Group Number _____

Expiration Date: _____

Name of Insured _____

First

Middle

Last

Patient's Relationship to Insured?

Self

Child

Spouse

Guardian

Other

Birth Date _____

Retire Date (if applicable) _____

Gender

F

M

Phone () _____

Name of Insured's Employer _____

Address of Insurance Holder _____

(If different from Patient Address)

City _____

State _____

Zip _____

Additional Patient Information

Marital Status

Single

Married

Divorced

Separated

Widowed

Patient's Employment Status

Full-Time

Part-Time

None

Retired

Spouse's Employment Status

Full-Time

Part-Time

None

Retired

Student Status (If Applicable)

Full-Time

Part-Time

None

Preferred Pharmacy _____

LOCATION _____

Patient's Employer _____

ZIP CODE _____

Referring Physician _____

All other Physicians _____

Emergency Contact Information - Primary Contact

Name _____

Relationship _____

Home Phone () _____

Cell Phone () _____

Work Phone () _____

Street Address _____

City _____

State _____

Zip _____

Patients' Rights Under HIPAA and Red Flags Rule

Patients have the right to inspect or obtain a copy of their protected health information (PHI) that is maintained in the patient's designated record set. Patients will be charged a fee for any requested copies of their PHI. The fee will be consistent with Alabama law and HIPAA regulations. Patients may request a copy of their PHI to be mailed to them. If an error is discovered in the patient's PHI or a record in a designated record set, then the patient has the right to have Tuscaloosa Lung, Critical Care & Sleep amend their information. However, Tuscaloosa Lung, Critical Care & Sleep reserves the right to deny an individual's request for amendment under conditions listed by HIPAA. Tuscaloosa Lung, Critical Care & Sleep also reserves the right to deny access to any patient's records under conditions listed by HIPAA. If a patient is denied the right to view their records, then a written denial will be furnished to the individual in a timely manner.

In general, parents will be able to access and control the health information about their minor children. When a minor opts to view their medical records without parental consent when allowed by state or other applicable laws, the minor may exercise their privacy rights attributed by the Privacy Rule.

Patients have a right to review who their PHI has been transmitted to within six years prior to the date on which the request was made, except for conditions listed under HIPAA regulations.

All other sensitive patient information is strictly confidential and protected by Tuscaloosa Lung, Critical Care & Sleep according to the Red Flags Rule. Any "red flags" or discrepancies in documents or patient information that suggest identity theft or fraud will be investigated by Tuscaloosa Lung, Critical Care & Sleep. If the fraudulent activity involves the patient's PHI, the existing HIPAA policies and procedures will apply.

For a more detailed version of HIPAA or Red Flags Rule regulations, please ask a Tuscaloosa Lung, Critical Care & Sleep staff member.

I have read and understand my Patients' Rights as specified by HIPAA.

Date

Patient

Family and friends with whom we may discuss your health

Name and Relationship: _____

Name and Relationship: _____

Name and Relationship: _____

Name and Relationship: _____

Name: _____ Birthday: _____ Date: _____

| | | | | |
|--|------------------------------------|-----|----|------|
| Past Medical History: Have you ever had? | | | | Year |
| | Diabetes | Yes | No | |
| | Heart Disease | Yes | No | |
| | High Blood Pressure | Yes | No | |
| | Asthma, Emphysema, or COPD | Yes | No | |
| | Cancer | Yes | No | |
| | Thyroid Disease | Yes | No | |
| | Stomach Problems(ulcer, heartburn) | Yes | No | |
| | Surgery | Yes | No | |
| | Colonoscopy | Yes | No | |
| Stool Checked for Blood | Yes | No | | |

| | | | |
|---|----------------------------|-----|----|
| Family History Any close relative ever had: | Diabetes | Yes | No |
| | Heart Disease | Yes | No |
| | High Blood Pressure | Yes | No |
| | Asthma, Emphysema, or COPD | Yes | No |
| | Stroke | Yes | No |
| | Cancer | Yes | No |

Allergic to any medicines? Yes or No
 Ever had the pneumonia shot? Yes or No If so year? _____
 Last mammogram: _____
 Have you been tested for osteoporosis? Yes or No If so year? _____

Social History:
 Marital status: Married Single Divorce Widow/er
 How much do/did you smoke? (packs per day) 0 ½ 1 2 Other _____
 How much alcohol do you drink? _____
 Any recreational drugs? (Marijuana, cocaine, ect...) _____
 Type of work you do/did? _____
 How far did you go in school? _____

Name: _____ Birthday: _____ Date: _____

| | |
|--|---|
| Review of Systems Circle what you have had in the last week, please. | Fever Weight Loss or Gain |
| | Double vision Wear Glasses/ Contacts |
| | Dizziness Bloody nose Deafness |
| | Chest pain Palpitations Swelling |
| | Wheezing Cough Shortness of breath Coughing up Blood |
| | Diarrhea Heartburn Nausea/ Vomiting Abdominal (Stomach) Pain |
| | Blood in urine or stool Painful urination Urinary incontinence |
| | Back Pain Joint swelling or stiffness |
| | Rash Breast lumps |
| | Seizures Mental status changes |
| | Hallucinations Depression Anxiety (nerves) |
| | Enlarged Glands Bleeding |
| | Hair loss Heat/ Cold intolerance Runny nose Watery/ Itchy eyes |

Thank you for helping us help you. Please take to the check-in window when finished.