



Leaders in helping you breathe easy & sleep well.

Thomas M. Siler, MD, FCCP, FAASM
Pulmonary Disease & Sleep Medicine Specialist

Frank S. Calandrino, Jr., MD, FCCP
Pulmonary Disease & Sleep Medicine Specialist

Sergio G. Garcia, MD, FCCP
Pulmonary Disease & Sleep Medicine Specialist

V. Christine Champagne, MSN, ANP-BC, CCRC
Nurse Practitioner

Jill E. Aufmuth, MSN, ANP-BC
Nurse Practitioner

Stacey L. Brown, RN, CS, FNP, ACNP
Nurse Practitioner

Mitchell P. Champagne, RPh, CCRC
Research Director

Susan L. Townsley, RPSGT, RRT, RPFT
Sleep Coordinator

Experienced, comprehensive & highly capable care for...

- Infection, disease & cancer of the lungs
- Coughing, wheezing & shortness of breath
- Fluid in the lungs & uncontrolled edema
- Chest tightness
- Coughing up blood
- Sore throat
- Snoring & sleep apnea
- Excessive daytime sleepiness & drowsy driving
- Restless leg syndrome & periodic limb movement disorder
- Insomnia
- Narcolepsy

Advanced, credentialed & dedicated...

- Board-certified pulmonology & sleep medicine specialists
- Experienced pulmonary researchers
- Available clinical trials for eligible patients
- Advanced capabilities & technologies
- Three nurse practitioners on staff
- The region's first & only AASM-accredited sleep center
- Friendly & knowledgeable registered sleep technologists
- Individualized, compassionate care

Making it easy to get the focused care you need...

- Lunchtime appointments available
- Insurance accepted & filed
- Visa, MasterCard & Discover cards welcome
- Free parking, including valet parking
- Handicapped-accessible

REGISTRATION FORM

Date: _____

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (Middle) _____

Street Address: _____ City: _____ State _____ Zip _____

Date of birth: _____ / _____ / _____
month day year

Home phone: (____) _____ - _____ Cell phone: (____) _____ - _____

E-mail _____ @ _____ . _____

Patients Social Security Number: _____ - _____ - _____ Sex: Male _____ Female _____

Marital Status: Single _____ Married: _____ Divorced: _____ Widowed: _____

Spouse's Name: _____

Emergency Contact: _____ Phone: (____) _____ - _____

Patient's Employer: _____ Occupation: _____

Employer's phone: (____) _____ - _____

PATIENT CONTACT INFORMATION

I wish to be contacted: (please check all that apply)

Home phone: (____) _____ - _____

OK to leave message with detailed information

OK to leave message with call back number only

Work phone: (____) _____ - _____

OK to leave message with detailed information

OK to leave message with detailed information

Release of information: All aspects of my healthcare

Do not give out any information unless specifically authorized

OK to discuss with: _____

MEDICAL INFORMATION

Primary Care Physician: (Last) _____ (First) _____

Primary Care Physician's phone: (____) _____ - _____

MAY WE ASK WHO REFERRED YOU TO US?

Family Member: _____ Friend _____ Physician: _____ Advertisement: _____ Other: _____

If referred by a physician: (Last) _____ (First) _____ (Telephone) (____) _____ - _____



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REGISTRATION FORM continued

WHAT BRINGS YOU TO US?

Please describe your current complaint or reason you are seeing our doctor: _____

Previous Records/Testing	Where	When
Physicians records (please bring copies of physicians records)	_____	_____

Recent Hospitalization	_____	_____
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Chest X-rays	_____	_____
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CT Scan	_____	_____
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Breathing Tests	_____	_____
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Heart Tests	_____	_____
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INSURANCE INFORMATION

Primary Insurance: _____

ID Number: _____ Group Number: _____

Phone Number: (____) _____ - _____ Referral: Yes _____ No _____

Policy Holder: _____

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Phone Number: (____) _____ - _____ Referral: Yes _____ No _____

Policy Holder: _____

I HEREBY AUTHORIZE THE OFFICE OF MIDWEST CHEST CONSULTANTS, PC TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO MY PHYSICIAN AT MIDWEST CHEST CONSULTANTS, PC. **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.** I ACKNOWLEDGE THE ABOVE INFORMATION TO BE ACCURATE.

PATIENT'S SIGNATURE: _____ DATE: _____