MIDWEST CHEST CONSULTANTS, P.C.
REGISTRATION FORM

PATIENT INFORMATION

Patient Name: (Last) _____ (First)_____ (MI)_____

Address: _____ (City) _____ (State) _____ (Zip) _____

Date of Birth: _____/_____/_____ Soc Sec #: _____ Sex: M F

Phone #: Home: ( ) _____ Cell Phone: ( ) _____ Work: ( ) _____

E-Mail: _____ @ _____

Race: _____ (optional) Primary Language: _____

Marital Status: Married Single Divorced Widowed

Patient's Occupation: _____

Patient's Employer: _____ Phone: ( ) _____

Spouse's Name: _____ Date of Birth: _____/_____/_____

Emergency Contact: _____ Relationship: _____

Phone #: ( ) _____

MEDICAL INFORMATION

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

Phone #: ( ) _____ City: _____ Last Seen: _____

PATIENT INFORMATION RELEASE (HIPPA REQUIRED)

Home Phone #:

☐ OK to leave message with detailed information **OR**

☐ OK to leave message with call back number only

Cell Phone #:

☐ OK to leave message with detailed information **OR**

☐ OK to leave message with call back number only

I wish to be contacted first by: ☐Home ☐Cell ☐Work

☐ OK to discuss medical information with: _____ **OR**

☐ Do **NOT** give out any information, even to family, unless specifically authorized. Medical information will be released to your primary physician and insurance company.

INSURANCE RELEASE INFORMATION

I hereby authorize the office of Midwest Chest Consultants, PC to release 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. I understand I am financially responsible for any balance not covered by my insurance carrier. In the event that I would fail to pay my bill, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees, and court costs). In the case of a returned check there will be and additional $25.00 charge. I acknowledge the above information to be accurate.

PATIENT SIGNATURE: _____ **DATE: _____**

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

Name:_____ Date:_____

Date of Birth:_____/_____/_____
Month Day Year

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

_____

_____

When did problem(s) begin? _____

ALLERGIES AND/OR MEDICINE REACTIONS

Do you have allergies or reactions to any medications/substance? Yes_____ No_____

If yes, type of reaction: (ex. Rash, swelling, etc…)
Rx/Substance:_____ Reaction: _____

Rx/Substance:_____ Reaction: _____

Rx/Substance: _____Reaction: _____

Rx/Substance: _____ Reaction: _____

SMOKING/ALCOHOL HISTORY

Have you / Do you Smoke?

Never_____ Currently_____ Past/Quit_____ Date Quit_____

Packs per day_____ Number of years_____

Other:

Pipe:_____ Cigar_____ Snuff____ Chew_____ Marijuana_____ Second Hand Smoke_____

Are you interested in quitting? Yes_____ No_____
Alcohol Consumption: Daily_____ Weekly_____ Monthly_____ Occasionally_____

What is your current activity level: Active_____ Sedentary_____ House Bound _____

Have you traveled outside of the US in the past five years? Yes_____ No_____
(If yes, where)_____

Current Occupation: _____

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

<u>HOSPITALIZATION / SURGERIES</u> (NOT LISTED ELSEWHERE) – TYPE AND DATE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Date of your most recent immunizations:
Influenza (Flu): _____ Pneumonia: _____

If you have ever had a listed condition in the past, please check the Past column.
If you are presently troubled by a listed condition, please check the Present column.
If you have not experienced a problem, please check never.

	Past	Present	Never	
Cough	☐	☐	☐	Productive: Yes___ No_____ Color:_____ Blood in Sputum: Yes____ No____
Shortness of breath	☐	☐	☐	When: Activity_____ At Rest_____ Wakes up at Night_____
Wheezing	☐	☐	☐	With Activity_____ Worse at Night_____
Lung Disease	☐	☐	☐	Emphysema_____ Asthma_____ Chronic Bronchitis_____ COPD_____
Heart Disease	☐	☐	☐	Heart Attack_____ CHF_____ Palpations_____ Irregular Rhythm_____
Sinus/Nasal Problems	☐	☐	☐	Drainage_____ Color_____ Congestion_____
High Blood Pressure	☐	☐	☐	
Stroke	☐	☐	☐	
Pain	☐	☐	☐	Location_____
Cancer	☐	☐	☐	Location:_____ When:_____
Diabetes	☐	☐	☐	Insulin_____ Oral Medicines_____ Diet Controlled_____
Arthritis	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Congenital Disease	☐	☐	☐	
Immune Disease	☐	☐	☐	
Seizures	☐	☐	☐	
Headaches	☐	☐	☐	When: Any Time of Day_____ Morning_____ Evening_____
Weight Gain	☐	☐	☐	
Weight/loss	☐	☐	☐	
Depression	☐	☐	☐	
Anxiety	☐	☐	☐	
Sleep Problem	☐	☐	☐	Snoring_____ Gasping for Breath_____ Insomnia_____
Restless Legs	☐	☐	☐	During the Day_____ Worse at Night: Yes_____ No_____
Blood Clots	☐	☐	☐	Location: _____ When: _____
Dizziness	☐	☐	☐	
Abnormal Chest X-Ray	☐	☐	☐	Location: _____ When:_____
Other	☐	☐	☐	_____

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

FAMILY HISTORY

Father: Alive_____ Deceased_____ Cause_____
Grandfather: Alive_____ Deceased_____ Cause_____
Grandmother Alive_____ Deceased_____ Cause_____

Mother: Alive_____ Deceased_____ Cause_____
Grandfather: Alive_____ Deceased_____ Cause_____
Grandmother: Alive_____ Deceased_____ Cause_____

LIST OF CURRENT MEDICIATIONS

NAME OF MEDICATION	STRENGTH	TIMES PER DAY	REASON/USED TO TREAT

OTHER CONCERNS/INFORMATION