Austin Pulmonary

# PATIENT INFORMATION

Name: ______________________________________________________________________________
First Middle Last

Address: ___________________________________________________________________________

City/St/Zip: ________________________________________________________________________

Phone: Home: ________________________ Work: _________________________ Cell: __________________________

Date of Birth: _______________________ Sex: **M** **F** Marital Status: Married Single Divorced Separated Other

Your email address: ____________________________________________________________________

Preferred Method of contact: Home Cell Work Portal Letter No preference

Pharmacy: ____________________________________________Phone: ____________________________

Emergency Contact: Name: _________________________________ Phone: ___________________________________

Referring physician: _______________________________ Primary Care Physician: ______________________________

**Primary Insurance Co.**: ____________________________________________________________________

Policyholder/subscriber name: ____________________________________ Policy holder DOB: _____________________
Relationship to the patient: Self Spouse Dependent

**Secondary Insurance Co.**: __________________________________________________________________

Policyholder/subscriber name: __________________________________ Policy holder DOB: _______________________
Relationship to the patient: Self Spouse Dependent

| | | |
|---|---|---|
| Is this workers comp? | Yes | No |
| Are you in a nursing home? | Yes | No |
| Are you on hospice? | Yes | No |

**Ethnic Group:**
Hispanic or Latino
Not Hispanic or Latino
Prefer not to disclose

**Race:**
Asian
African American
Native Hawaiian
Other Pacific Island
Other Race
White
Prefer not to disclose

Language: _________________________ (Required for government electronic medical records meaningful use documentation.)

I hereby assign, transfer, and set over to Austin Pulmonary Consultants, PA all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

___________________________________________________________ _________________________
Patient or Authorized Signature Date


**austinpulmonaryconsultants.com**

**North office**
3600 W. Parmer Ln Ste.106
Austin, TX 78727
**P** 512-977-0123 **F** 512-977-0126

**South Office**
5920 W. William Cannon Dr. Bldg 1 Ste 150
Austin, TX 78749
**P** 512-441-9799 **F** 512-441-9814

**Medical Release**

Patient's Name ________________________________________DOB ____________________
Patient's Address ____________________________________ City________________________
State __________ Zip ____________ Phone ______________

1. Austin Pulmonary Consultants is authorized to release Patient's information to (Physician / Hospital)
Name ____________________________________________ Phone________________________
Name ____________________________________________ Phone________________________
Name ____________________________________________ Phone________________________

2. Entity(ies) who may release information to Austin Pulmonary Consultants
Name ____________________________________________ Phone________________________
Name ____________________________________________ Phone________________________
Name ____________________________________________ Phone________________________

3. The specific information that should be disclosed:
________LAST 24 MONTHS OFFICE NOTES/LABS/X-RAYS ________ LAST 12 MONTHS OFFICE NOTES/LABS /X-RAYS OTHER (BE SPECIFIC):
________________________________________________________________________________
________________________________________________________________________________

4. This authorization will expire on the following date or event:____________________________

If no expiration date or event is listed, the authorization will expire one year after the date of the authorization.

WE PROVIDE THE PAST TWO YEARS OF RECORDS TO OTHER PROVIDERS

Signed:
________________________________________________________Date____________________
Patient

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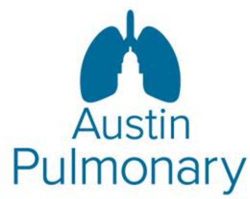



I have been given an opportunity to review a copy of:

Notice of Privacy Practices of Austin Pulmonary Consultants, PA

Office policies and procedures of Austin Pulmonary Consultants, PA

Patient signature: _______________________________________________Date:______________

Printed Name: _________________________________________________

If patient cannot legally sign, please complete the section below:

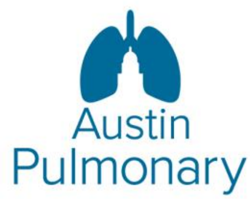
Patient's personal representative's signature: __________________________________________

Printed Name: _________________________________________________Date: _____________

Advance Practice Nurse Consent for Treatment

This facility has on staff Advance Practice Nurses to assist in the delivery of medical care. An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well a provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries. I have read the above, and hereby consent to the services of an Advance Practice Nurse for my health care needs. I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Signature: _________________________________Date: ______________________________




## RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE READ CAREFULLY

I authorize Austin Pulmonary Consultants, PA to release my protected health information to the family members or friends listed below. This is not a release of medical records. I understand that I have the right to revoke this authorization at any time. I understand the revocation will NOT apply to the information that has already been released. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

Patient Name: ____________________________________________________________________

I authorize the release of my protected health information to the following person(s):

Name: __________________________________ Relationship: ____________________________

Name: __________________________________ Relationship: ____________________________

Name: __________________________________ Relationship: ____________________________

Name: __________________________________ Relationship: ____________________________

Name: __________________________________ Relationship: ____________________________

Signed: ___________________________________________________Date: ____________________

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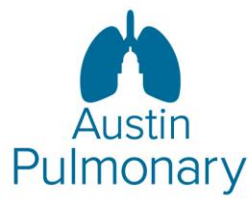


**Medication List**

Name: ________________________________________Today's Date: _________________________________

Medication Allergies and Reactions:

___________________________________
___________________________________
___________________________________
___________________________________

Food Allergies and Reactions:

___________________________________
___________________________________
___________________________________
___________________________________

Iodine Allergy: YES NO
Peanut Allergy: YES NO
IV Contrast Allergy: YES NO NOT SURE

Please list all of the medications you take (both prescribed and over the counter). After the name of the medication, please list the strength followed by the dosing instructions.

| Item | Name of Medication | Strength | Directions |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |
| 16 | | | |
| 17 | | | |
| 18 | | | |

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As we have updated our EMR system, we would like to ensure we have all of your healthcare providers in our system to ensure continuity of care. Please fill out the information below to ensure we have all the necessary information to provide the best quality of care.

| Outside Physicians Name | Specialty/Location/Phone Number |
|---|---|
| | |
| | |
| | |
| | |

***I authorize Austin Pulmonary Consultants to electronically obtain my current and past prescriptions when available electronically:***

Prescription List Release from Pharmacy: **Yes**/ **No** (This allows us to be updated with current medications)

Preferred Pharmacy: _________________________ Street Name/Cross Street: __________________________

**Immunizations: Pneumonia: Yes/No Date: __________ Flu: Yes/No Date: __________**

**We now have more options available for appointment reminders. How would you like to be notified of your appointments at Austin Pulmonary?**

Text: _________________________________

E-mail: _________________________________

Voice: _________________________________

**Please be advised that for FMLA or Disability paperwork, there is a $25 charge for completing that paperwork.**

**_________(initial)**

**Our patient portal is now active. If you would like more information, please talk to the front desk staff.**

__________ __________________________ _____________________________ __________

DOB Patient Printed Name Patient Signature Date

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