ONSLOW
PULMONOLOGY
ASSOCIATES

237 Old White Street, Suite 1 • Jacksonville, NC 28546-6351
Phone: 910-577-4968 • Fax: 910-577-4988

Welcome to Onslow Pulmonology Associates. In an effort to accommodate our patients and provide the best possible care, we follow the below guidelines:

New Patient Appointments:
Please Bring In:

- We ask that all new patients bring new patient paperwork with them; otherwise they may need to be rescheduled due to time constraints. This paperwork can be mailed to the patient or printed off of our website.
- All of your current medications to include inhalers and medicines used in your nebulizer machine.
- Any radiological studies (MRI, CT or X-Ray) **on a disk** with the *printed radiology report*.
- Insurance card(s) and picture ID.
- Medical records regarding your care for this issue.

Your picture will be taken at the front desk for identification purposes.
Co-Pays and Cost Shares are expected at the time of service

We ask that you please arrive fifteen minutes prior to your appointment time

To confirm your appointment date and time, please contact the clinic at 910-577-4968. REMINDER CALLS ARE MADE ELECTRONICALLY 48-72 HOURS PRIOR TO YOUR APPOINTMENT.

Pulmonary Function Test: Many of our patients are scheduled for a pulmonary function test yearly; this will begin with your first appointment at our clinic. It is recommended that you do not use any inhalers, take any breathing treatments, drink caffeinated beverages, or smoke 4 hours prior to having this test done. *Please alert the front office staff if you have done any of the above prior to check in for the pulmonary function test.*

Canceling an appointment: Please cancel appointments as soon as possible. (24 hours in advance of your appointment time is appreciated) If you miss 3 (three) appointments without calling in advance to cancel your appointment, you risk being disengaged from the practice.

Late appointments: In order to serve our patients in a timely manner we *adhere strictly* to our schedule. If you are not on time for your appointment, we may ask you to reschedule to another date and time.

Special needs and considerations: If you have any special needs or requirements please make sure that you bring these to the attention of our staff before your scheduled appointment time. Courtesy wheelchairs are available for your use.

Medication refills: Please be advised that prescription refills may take up to **72 business hours**. Not all medications can be called into the pharmacy, and will need to be picked up by the patient. We will not refill medications after clinic hours, or during weekends or holidays.
At the request of our physicians, all cellular telephones must be turned off upon entering our clinic.
If you must use your phone please step outside.

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Patient Demographic Form (Please Print Clearly) All information is confidential.

PATIENT INFORMATION			
Patient's FULL Name:		Date of Birth:	Social Security #:
Sex: ○ Male ○ Female	Race:	Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino	
Street Address:		State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	
Place of Work:	Work Address:	Job Title:	
Emergency Contact Name:		Phone:	
Primary Care Physician:	Pharmacy:		

INSURANCE INFORMATION		
Primary Insurance Carrier Name:	Policy ID/Tricare Sponsor SS#:	Group #/Tricare Sponsor D.O.B:
Insured's Name:	Patient's Relation to Subscriber:	
Secondary Insurance Carrier Name:	Policy ID/Tricare Sponsor SS#:	Group #/Tricare Sponsor D.O.B:
Insured's Name:	Patient's Relation to Subscriber:	

REQUIRED SIGNATURE

Payment in full is required for all services at the time they are rendered, unless you are in a prepaid insurance plan in which we participate. Applicable co-payments and deductibles will be collected. I understand that I am financially responsible for all services rendered that are not paid by my insurances. I agree to pay any undisputed billing from the practice within 30 days of receipt of the bill. I further understand that I may be charged a fee for missed appointments, returned checks, etc. in accordance with the office financial responsibility.

Patients Signature: _____ **Date:** _____

I authorize the release of information concerning my healthcare, advice and treatment provided for the purpose of the evaluation and administering claims for insurance benefits. For Medicare beneficiaries this serves as a lifetime authorization for release of information. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow Pulmonology Associates.

Patients Signature: _____ **Date:** _____

Patient Portal allows you to have access to Appointments, Lab Results, Medication Refill, Medical Records, and more.
If you are interested please provide your email below:

Email: _____

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Communication Release

Your signature is required if you wish anyone other than yourself to correspond with the doctor or staff in regard to your care, appointments, or account status.

Patient Name: _____

Patient Date of Birth: _____

Authorized Contact Name: _____

Relationship to Patient: _____

Contact Phone Number: _____

Authorized Contact Name: _____

Relationship to Patient: _____

Contact Phone Number: _____

Signature: _____ Date: _____

Phone Release

I authorize Onslow Pulmonology Associates to leave messages with anyone that answers my phone or on my answering machine in regards to appointments, test results, or issues in regard to my care.

Signature: _____ Date: _____

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Acknowledgement of Receipt of Onslow Ambulatory Services, Inc.

Notice of Privacy Practices

Our Notice of Privacy Practices and Patient Rights and Responsibilities are located at the front desk. Please feel free to read over it while you wait, or at your request, we will provide you with a written copy.

Notice of Privacy Practices:

I acknowledge that I was made aware of the Notice of Privacy Practices of Onslow Ambulatory Services (Including, but not limited to, Internal Medicine & Primary Care, Central Coast Dermatology, Onslow ENT, Onslow Pulmonology Associates, and Onslow Surgical Clinic). I understand that the notice describes the uses and disclosures of my protected health information by Onslow Ambulatory Services and informs me of my rights with respect to my protected health information.

For more information, please contact the Onslow Ambulatory Service's HIPAA Privacy Officer at 910-577-2852.

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

Staff Initials: _____

Patient Rights and Responsibilities:

I acknowledge that I was made aware of the Patient Rights and Responsibilities for Onslow Pulmonology Associates and its location. I understand that it explains that I am a partner in my health care and that I have the rights and responsibilities while in this facility.

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

Staff Initials: _____

☐ Patient refuses to sign or patient deferred signing until further review.

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Narcotic Medication Agreement

Narcotic medications can be very addictive and must be taken with caution. For this reason, our physicians prescribe narcotic medications only in appropriate situations, such as after surgery.

We do not specialize in long term pain management. Depending on the nature of your surgery or illness we may prescribe narcotic medication for a limited time. If the pain or illness becomes a long term condition or if you require narcotic medications frequently, you may be referred to a pain management clinic or back to your primary care physician.

It is the strict policy of this clinic that all medications will not be refilled on weekends, holidays, or after hours.

****Please do not drive or operate machinery while taking pain medications. ****

I, _____acknowledge that I have read and understand the Onslow Pulmonology Associates narcotic medication policy.

Patient Signature: _____ Date: _____

Physician Signature: _____

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Authorization to Release Healthcare Information

Patient's Name:	Date of Birth:
Previous (Maiden) Name:	Social Security #:

I authorize and request _____
to release healthcare information to:

Onslow Pulmonology Associates
237 Old White Street, Suite 1
Jacksonville, NC 28546
Phone: 910-577-4968 Fax: 910-577-4988

This authorization and request applies to:

☐Healthcare information related to the following treatment, condition, or dates:

_____

☐All healthcare information.
☐Other: _____

This authorization will expire: (Choose One)

☐ Two years after death of patient
☐ Upon written revocation
☐ Future date: _____

By signing below, I understand:

- I authorize the use and/or disclosure of my protected health information as described in the document.
- I may revoke this authorization at any time by providing written notice of my revocation. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before notice of revocation of authorization was received.
- I may refuse to sign this authorization and the request will be considered null and void.
- Onslow Pulmonology Associated may not condition my treatment on my refusal to sign this authorization

Patient Signature: _____ Date: _____

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Patient Name:	Date of Birth:	Age:
Primary Care Provider:	Referring Provider:	
Chief Complaint:	How Long:	

PAST MEDICAL HISTORY

☐Anemia	☐Diabetes, Type I	☐Hiatal Hernia	☐Pneumonia
☐Anesthesia Problems	☐Diabetes, Type II	☐High Blood Pressure	☐Seizures
☐Bleeding	☐Dizziness	☐High Cholesterol	☐Sleep Apnea
☐Blood Clot	☐Food Allergies	☐Hoarseness	☐Snoring
☐Childhood Disease	☐Gastric Reflux	☐Insomnia	☐Stroke
☐Cancer (skin, ect.)	☐Headaches/Migraine	☐Kidney Disease	☐Tinnitus
Type:	☐Heart Attack	☐Liver Disease	☐Thyroid Disorder
☐Depression	☐Heart Disease	☐Lung Disease	☐Tuberculosis

PAST SURGICAL HISTORY

☐Back Surgery	☐Lung Surgery
☐Bronchoscopy/Lung Biopsy	☐Neck Surgery
☐Eye Surgery	☐Orthopedic Surgery
☐Gallbladder Surgery	☐Sinus/Nasal Surgery
☐Heart Surgery	☐Tonsillectomy/Adenoidectomy

Other:

Past Hospitalization:

MEDICATION HISTORY

Medication:	Dosage:

DRUG ALLERGIES

☐No Known allergies ☐YES (Please list and include reaction)

FAMILY HISTORY

	Father	Mother	Siblings	Child(ren)
Anesthesia Problems	☐	☐	☐	☐
Bleeding/Clotting	☐	☐	☐	☐
Cancer-List Type	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High blood Pressure	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Deceased	☐	☐	☐	☐

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SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Exercise regularly:** ☐ YES ☐ NO
Housing: ☐ House ☐ Apartment ☐ Mobile Home ☐ Other	**Do you live with a smoker?** ☐ YES ☐ NO
Do you have problems with water leaks, wet spots, or mold in your home? ☐ YES ☐ NO	
Do you have pets in your home? ☐ Type:	Amount:
Do you consume caffeine? ☐ YES ☐ NO	**How many drinks per day?**
When was your last PPD?	**Known exposure to TB?** ☐ YES ☐ NO

Alcohol Usage	Tobacco Usage	Other
☐ Currently every day Amount: Type: ☐ Currently some days ☐ Former Quit Date: ☐ Never	☐ Currently every day Amount: Type: ☐ Currently some days ☐ Former Quit Date: ☐ Never ☐ Exposure to passive smoke	☐ Prior or current recreational drug use ☐ Other risk factors for HIV Explain: ☐ Occupation:

REVIEW OF SYMPTOMS

Please check and symptoms that you **are experiencing currently**.

Constitutional	Musculoskeletal
☐ Daytime sleepiness	☐ Arthritis Type:
☐ Difficulty sleeping	☐ Back pain
☐ Fevers	☐ Gout
☐ Chills	☐ Joint pain/ ☐ swelling/ ☐ redness (circle one)
☐ Fatigue	☐ Muscle pain Where:
☐ Night sweats	☐ Osteoporosis
Cardiac	**Neurologic**
☐ Chest pain/angina	☐ Balance problems
☐ Circulation problems	☐ General/localized weakness
☐ Irregular heartbeat/murmur	☐ Memory loss/problems
☐ Leg pain or swelling	☐ Numbness in hands/feet ☐ (circle one)
Gastrointestinal	**Respiratory**
☐ Acid reflux	☐ Activity intolerance
☐ Constipation	☐ Coughing up blood
☐ Diarrhea	☐ Daily cough (productive/non-productive)
☐ Nausea/vomiting ☐ (circle one)	☐ Recurrent bronchitis
☐ Stomach ulcer/pain ☐ (circle one)	☐ Shortness of breath exertion/rest ☐ (circle one)
☐ Trouble/painful swallowing ☐ (circle one)	☐ Wheezing
Endocrine	**Psychiatric**
☐ Adrenal gland problems	☐ Feeling anxious/ ☐ depressed/ ☐ nervous (circle one)
☐ Excessive hunger	☐ Hallucinations
☐ Excessive thirst	☐ Insomnia
☐ Weight gain/loss ☐ (circle one)	☐ Suicidal attempts/thoughts ☐