PULMONARY CONSULTANTS
OF SOUTHWEST FLORIDA
Respiratory and Sleep Medicine
Always there for you.

REGISTRATION FORM

Referred to this office by: ____________________ **Primary Care Doctor**: ____________________

Patient Name: ______________________________ Sex: M or F DOB: ____________________

Local
Mailing Address: ______________________________ City: ____________________

State: ____________________ Zip: ____________________

If mailing address is different than physical address, please enter information here:

Street: ______________________________ City: ____________________

State: ____________________ Zip: ____________________

Mobile #: ____________________ Home Phone: ____________________

Alternate Phone: ____________________ Email: ____________________

Race: ____________________ Ethnicity: ____________________ Language: ____________________

Single Married Divorced Significant Other Widowed Student

Pharmacy: ______________________________ Pharmacy Phone #: ____________________

Spouse/Significant Other Name: ______________________________

Emergency Contact: ______________________________ Phone #: ____________________

Employment Status: Full-Time Part-Time Retired Disabled Not Employed

Present Occupation: ______________________________ Work #: ____________________

RELEASE OF INFORMATION & PATIENT CONSENT

I AUTHORIZE: Pulmonary Consultant of SWFL to release any information acquired in the course of my medical exam and treatment. I authorize all information to be released to my Insurance company, third party payers, case utilization, mange care review companies, Health Care Financing Administration. I further authorize information to be released to all other PCSWF agencies, affiliated Institution or Individuals who will be providing healthcare or social services to me.

I hereby authorize PCSWF to give the following people information concerning my test results, health status appointment times, medication, and procedure Information. PLEASE List names and relationships.

Name(s): ____

FINANCIAL AGREEMENT

I accept responsibility to ensure that all services are paid in full within 90 days of service.

I understand PCSWF will file all primary and secondary Insurance claims for me; however, if after 90 days my Insurance company has not processed my claim, it will then become my responsibility.

Print Name: ____________________ Signature: ____________________

HEALTH HISTORY

Patient Name:___________________________ DOB:______________________ Today's Date: ____________________

Reason for today's visit? ____

Are you allergic to any medication(s)?____

How many children do you have? ________________ Any major problems? ______________________

Do you have PETS: Y or N If yes, what kind? ____

Nutrition/Diet: ○Poor ○Average ○Good ○Excellent ○Vegetarian

Do you exercise? if so, how often? ____

Do/Did you smoke cigarettes? ○Yes ○No If so, how old were you when you started? ________________________

What year did you quit smoking? ______________ What is/was the most you smoked daily? _________________

Do you drink alcohol? If so, list daily amount _______ Do you have trouble sleeping at night? ○Yes ○No

Do you do any recreational drugs? _____________ Do you wear your seatbelt? ___________________

What **medical conditions** are you currently being treated for and how long have you been treated for this condition?

1.	4.
2.	5.
3.	6.

Please list any surgeries/procedures you have had and the dates:

1.	4.
2.	5.
3.	6.

Family History

Mother, did she have any major medical problems? ____

If deceased, approximate age and cause: ____

Father, did have any major medical problems?

If deceased, approximate age and cause: ____

# of Brothers: _____________ Any major medical problems? ____

# of Sisters: ______________ Any major medical problems? ____

List of Medication:

1.	5.
2.	6.
3.	7.
4.	8.