

TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

E. Duane Dilley, M.D.
Phan Nguyen, M.D.
601 Omega Drive, Suite 206
Arlington, TX 76014
817-465-5881

Patient Name: _____

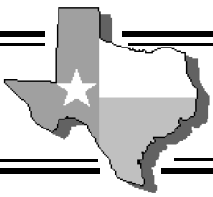
You have been scheduled for an initial consultation or hospital follow-up appointment with _____ on _____ at _____ with a check-in time of _____. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for this appointment.

- **Paperwork:** This must be completed before your appointment. Failure to do so may necessitate rescheduling your appointment. Leave blank any questions you don't understand and we can help you. Otherwise, call our office if you have questions. If you are a new patient to our office, but we have seen you in the hospital, you are still required to fill out the paperwork completely. Be sure that all highlighted lines have a signature. The HIPAA privacy information is available in our office for your review if you are not already familiar with its contents.

Health Insurance Claim Form: You need only to sign on lines 12 and 13. You do not need to complete the entire form.

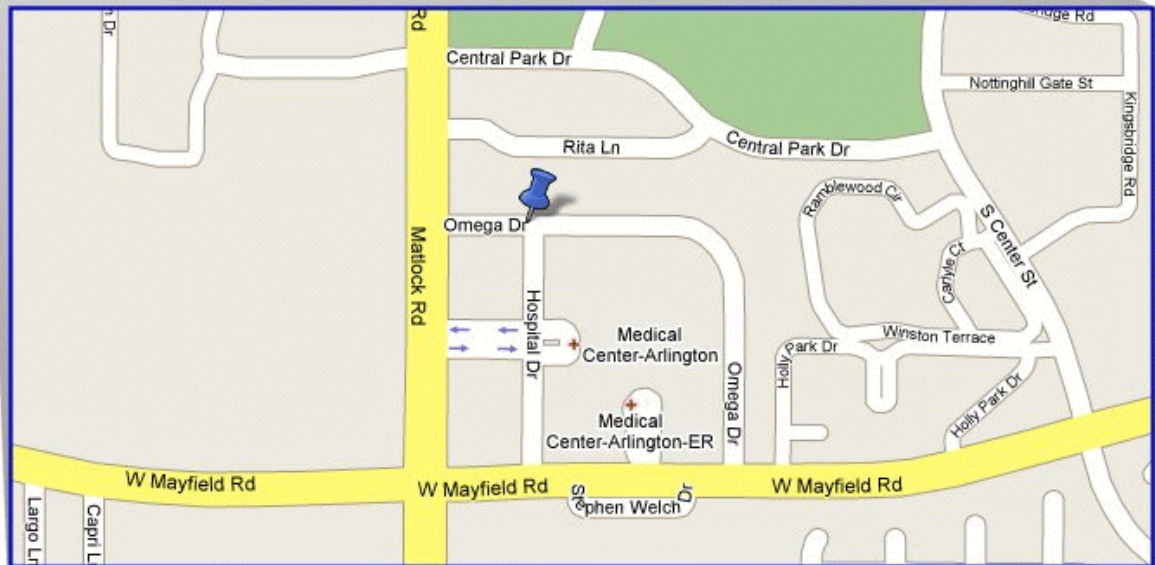
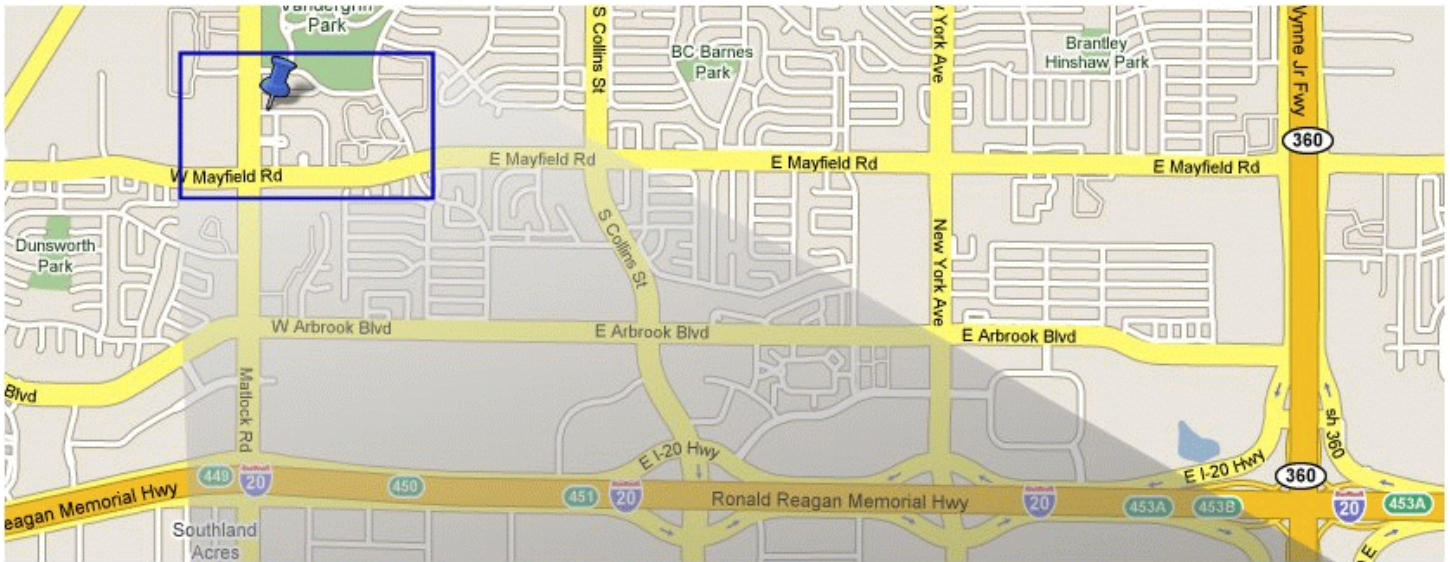
- **X-rays:** New Patients Only (this does not apply to hospital follow-up patients)
Bring: Chest x-rays and CT scans of the chest done within the last three to six months. Must be actual films. If you have been told by your Primary Care Physician's office or an x-ray department that the films would be sent to our office, please call us and make sure the films are here, before your appointment. Failure to do so may necessitate doing another x-ray or rescheduling your appointment if the films involve CT scans.
- **Referrals:** Make sure you have requested a referral from your primary care physician if your insurance requires this. Please have your referring physician fax to our office or send with you any recent office notes and lab work.
- **Insurance cards:** We will need a copy of your insurance card and driver's license. If you have Medicaid, we need a current copy (form 3087).
- **Payment:** Co-pays are due at time of visit. Insurance will be filed.
Out-of-Network - depending on your insurance and benefits, you may be required to pay part or all of the charges associated with your visit.
Hospital Follow-up Patients with a balance: Payment is expected at the time of your visit. A coupon book can be made available to you for payments if this meets your financial needs. Please let us know.
- **Need to reschedule?** Please call us at least 24 hours prior to your appointment if you need to cancel or reschedule. Unless canceled or rescheduled at least 24 hours in advance, our policy is to charge for late notification/missed appointments at the rate of \$25.00 per incident. Insurance does not cover this charge and it would have to be paid before a new appointment could be scheduled. Please help us serve you better by keeping scheduled appointments.

We look forward to meeting you at your first office visit. If we can assist you with questions prior to your visit, please feel free to call. You may also see our website at <http://www.texaspulmonary.com> for answers to questions you may have.



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DIRECTIONS:

1. Major crossroads are south I-20, and Matlock Road
2. We are north of Mayfield and east of Matlock
3. Turn east onto Omega drive. Our building is on the left-hand side.

PATIENT REGISTRATION FORM

Date: _____

Patient Name _____ Birth Date _____ Sex _____

Are you currently residing in a skilled nursing facility? Yes No If so, name of facility _____

Home Address _____ Street _____ City _____ State Zip+4 _____

Home Phone _____ Cell Phone _____ Social Security Number _____

Patient Employer _____ Work Phone _____

Employer Address _____ Street _____ City _____ State Zip+4 _____

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

Spouse's Name _____ Spouse's Employer _____

Spouse's Work Phone _____ Address _____

Referred By _____ Phone _____ Fax _____

Address _____ Street _____ City _____ State Zip+4 _____

Primary Care Physician _____ Phone _____ Fax _____

Address _____ Street _____ City _____ State Zip+4 _____

List other physicians you are currently seeing _____

Notify in case of emergency: (Do not list anyone who lives with you)

Name _____ Phone _____ Relationship _____

Address _____ Street _____ City _____ State Zip _____

Have you signed a: Living Will: Yes No DNR (Do Not Resuscitate): Yes No (Please provide a copy)

Durable Power of Attorney: Yes No Date signed: _____ (Please provide a copy)

Pharmacy _____ Phone _____

Are you currently using a DME (Durable Medical Equipment) Company? Yes No

If yes, which one? _____ Phone _____

If no, who does your insurance company require you to use? _____

Who does your insurance company require you to use for: Lab _____ X-ray _____

Is this a work-related illness? Yes No Date of illness or injury _____ Date last worked _____

Cause of accident, if any _____

Only with your written request will we release information regarding your medical condition to a family member. Do you wish information to be released to a family member? Yes No

Please list family members by name and relationship to you. _____

I hereby authorize release of my medical records from _____ to the physician(s) indicated below.

Arlington - North
Joseph Austin, Jr., M.D., FCCP
Jack G. Gilbey, Jr., M.D., FCCP
Luis F. Guerra, M.D., FCCP
Mitchell C. Kuppinger, M.D., FCCP
David H. Plump, M.D., FCCP
Tony H. Su, M.D., FCCP

Bedford
Gary L. Jones, M.D., FCCP
James T. Siminski, M.D., FCCP
Donald L. Washington, Jr., M.D.
Burlison
Dereje S. Ayo, M.D.
Henry S. Cunningham, M.D., FCCP

Fort Worth - Medical District 2
Steven Q. Davis, M.D.
Roger Gleason, M.D., FCCP
John T. Pender Jr., M.D., FCCP
David S. Hernandez, M.D.

Grapevine
R. L. "Lin" Cash, Jr., M.D., FCCP
Timothy G. Schroeder, M.D., FCCP

Arlington - South
E. Duane Dilley, M.D., FCCP
Phan Nguyen, M.D.

Fort Worth - Medical District 1
John R. Burk, M.D., FACP
Stuart D. McDonald, M.D., FCCP
Kerim F. Razack, M.D., FCCP

Fort Worth - Southwest
Kevin G. Connelly, M.D., FCCP
Huy X. Duong, D.O.
David Maldonado, III, M.D.

Mansfield
John L. Tiu, M.D.

North Richland Hills
David R. Herrmann, M.D., FCCP
Madhu S. Kollipara, M.D.

Sleep Consultants, Inc.
Donald E. Watenpaugh, Ph.D.

Signature of Patient or Responsible Party

Date

PATIENT QUESTIONNAIRE:

Patient Name: _____ Date: _____

Why are you here to see the doctor today? Briefly describe your pulmonary (lung) problem. Tell when and how it began.

Have you ever had any pulmonary (lung) problems as a child (asthma, wheezing, shortness of breath, recurrent lung infections)? If yes, please list the problems.

Respiratory symptoms:

Shortness of breath:

When do you have shortness of breath?

On exertion At rest Both

How long has this been going on (days, weeks, months or years)? _____

If your shortness of breath happens on exertion, approximately how far can you walk or how much activity can you do before you become short of breath? _____

Does shortness of breath come on suddenly? Yes No

What, if anything, makes the shortness of breath better or worse?

Does it improve after coughing up thick sputum? Yes No

Is it improved after taking any particular medications? If yes, which ones?

Is it worse in any particular position (i.e.: lying down, bending over)?

Is it worse after eating? Yes No

Is it worse with exposure to dust, fumes, cold air, other?

Is the shortness of breath associated with: Circle all that apply.

Drenching sweats Blackouts Pounding heart Chest pain Wheezing

Swollen legs Fever Chills Nausea/vomiting

Cough:

How long have you had trouble with coughing? _____

Has your cough changed recently? Yes No

If yes, how has it changed? _____

Has your cough ever awakened you from sleep? If yes, how often does this occur?

Does your cough produce sputum? Yes No

If yes, what color? (Circle one or more)

Clear yellow white green tan brown red other _____

PATIENT QUESTIONNAIRE:

How much sputum do you produce over 24 hours?

Less than 2 tablespoons More than 2 tablespoons

Have you ever coughed up blood? If yes, when and how much? _____

What, if anything, makes your cough better or worse?

Is it improved after taking any particular medications? If yes, which ones?

Is it worse in any particular position (i.e.: lying down, bending over)?

Is it worse after eating? Yes No

Is it worse with exposure to dust, fumes, cold air, other?

Chest Pain:

Where exactly is the chest pain located (ie: front, back, left, right)? _____

When do you have chest pain?

On exertion At rest After meals

How long does the pain last?

Few seconds 5 minutes 15 minutes 1 hour All day

How long have you had chest pain?

Less than a year 1 to 3 years More than 3 years

Is the pain increasing in frequency or intensity? Yes No

What, if anything, makes the pain go away? Resting Eating Medication (list): _____

Past chest x-rays:

Location	Reason	Date (month and year)

Review of systems:

If you have had any of the following symptoms recently, please circle all that apply:

General: fevers chills night sweats (enough to soak your shirt or sheets)
weight loss/gain (how much? _____ In what amount of time? _____)

Head, eyes, ears, nose, throat:

itchy/watery eyes hay fever
post nasal drainage bleeding nose or gums
sore throat hoarseness
sinus congestion or drainage (color? _____)

Cardiovascular:

shoulder or arm pain swelling in your legs
shortness of breath when lying flat
awakening at night short of breath

PATIENT QUESTIONNAIRE:

Pulmonary: snoring insomnia daytime sleepiness
legs twitches/discomfort

Gastrointestinal: nausea vomiting diarrhea constipation heartburn
reflux indigestion abdominal/stomach pain

Genitourinary: bloody urine painful urination trouble starting/stopping

Musculoskeletal: joint pain or swelling muscle pain

Hematologic: easy bleeding or bruising

Lymphatic: swelling of lymph nodes under jaw, on neck, under arms or in groin

Skin: new rashes or spots

Back: pain or swelling

Neurological: headaches seizures passing out numbness/tingling in hands or feet

Past Medical History:

Please list any current or past medical illnesses and hospitalizations and the approximate dates:

Please list all surgeries and approximate dates:

Medications (prescription and nonprescription):

Name of medication	Dose	Times per day	Length of time used	Prescribing Physician

List **allergies** to:

Drugs: _____
Food: _____
Environment: _____

Social History:

Smoking history:

How many packs per day? _____ How many years have you smoked? _____
Have you smoked pipes or cigars? _____ When did you quit smoking? _____

PATIENT QUESTIONNAIRE:

Exposure to secondhand smoke: never rarely occasionally often regularly

Number of alcoholic drinks per week: _____

Illicit drug use: marijuana cocaine narcotics Valium LSD IV drug use

Have you ever had a blood transfusion? Yes No If yes, when? _____

Date of last flu shot: _____ Pneumovax: _____

Current occupation: _____

Previous occupations: _____

List any jobs, activities or hobbies where you were routinely exposed to chemicals, powders, dusts or other types of hazardous materials (i.e.: including asbestos, sandblasting and fumes)

Activity	Years of exposure	Type of hazardous exposure

Home environment in the last ten years. Circle all that apply:

- Dog Cat Bird Livestock Horses Gas heat Old carpets Central air Old drapes
Feather pillows Indoor insect problem

Have you or anyone in your family had tuberculosis or a positive PPD skin test? Yes No
If yes, when and what treatment was given? _____

Please list any travel in the last 20 years

Outside of local region	Foreign
_____	_____
_____	_____
_____	_____

Family History (include siblings, children and grandchildren; also make particular note of any diabetes, heart disease, strokes, hypertension, cancer, and asthma):

Family member	Age	Medical Problem	Or	Age	Cause of Death
Father					
Mother					
(Siblings)					
(Children)					

Appointment of Authorized Representative

1. Identifying Information

Patient's name _____

Member's name _____

Member's address _____

Member's plan identification # _____

Provider's plan identification # _____

Service not paid / not authorized by plan _____

Date(s) of service _____

2. Appointment. I, _____, appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as my authorized representative in requesting an appeal from _____ regarding its denial of services / denial of payment.

3. Directed payment. I agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to my authorized representative, and direct the plan to do so in that event.

4. Member's signature _____ **Date** _____

5. Witness's signature _____ **Date** _____

PLEASE
DO NOT
STAPLE
IN THIS
AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)							
CITY				STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY				STATE			
ZIP CODE				TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE				TELEPHONE (INCLUDE AREA CODE) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY						SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>							

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **X**

DATE

SIGNED **X**

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)						23. PRIOR AUTHORIZATION NUMBER									

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
From	To					CPT/HCPCS	MODIFIER														
MM	DD	YY	MM	DD	YY																
1																					
2																					
3																					
4																					
5																					
6																					

25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #							
SIGNED						DATE						PIN#		GRP#					

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Texas Pulmonary & Critical Care Consultants, P.A.
Acknowledgment of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority