RICHMOND Pulmonary MEDICINE

2905 Hylan Blvd, Staten Island NY 10306

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Patient Information

Full Name: _____
Date of Birth: _____
Gender: _____
Address: _____
Primary Phone Number: _____

Secondary Phone Number: _____
Email: _____
Emergency Contact Name: _____
Relationship: _____
Phone Number: _____

Primary Insurance Information:
Name of Insurance Company: _____

ID/Subscriber Number: _____

Subscriber Name: _____

Relationship to patient: _____

Primary Pharmacy/ Address/Phone Number:

_____

Secondary Pharmacy/ Address/Phone Number:

_____

Primary Care Physician: _____
Address/Phone Number: _____

Medical History

Patient name: _____ Patient DOB: _____

Medical Diagnoses Checklist

Please check all medical diagnoses that apply to you.

Pulmonary :

- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Pulmonary Fibrosis
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea
- ☐ Tuberculosis (TB)
- ☐ Lung Cancer
- ☐ Cystic Fibrosis
- ☐ Bronchiectasis
- ☐ Interstitial Lung Disease
- ☐ COVID-19 (past or current)

Cardiac:

- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Coronary Artery Disease
- ☐ Heart Failure
- ☐ Atrial Fibrillation
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Peripheral Artery Disease

Gastroenterology:

- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Inflammatory Bowel Disease (Crohn's/Ulcerative Colitis)
- ☐ Hepatitis B or C
- ☐ Fatty Disease Cirrhosis

Endocrinology:

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Thyroid Disorder (Hypo/Hyperthyroidism)
- ☐ Adrenal Insufficiency

Nephrology:

- ☐ Stroke or TIA (Mini-Stroke)
- ☐ Seizure Disorder / Epilepsy
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Migraines

Rheumatology:

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Lupus (SLE)
- ☐ Fibromyalgia

Nephrology:

- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Anemia
- ☐ Blood Clots (DVT or PE)
- ☐ Leukemia / Lymphoma
- ☐ Other Cancer: _____
- ☐ HIV/AIDS

Psychology:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia / Psychosis

Other:

- ☐ Obesity
- ☐ Autoimmune Disease (specify): _____
- ☐ Seasonal Allergies: _____

Smoking history:
☐ Current smoker ☐ Former smoker ☐ Never smoked

If yes, how many packs/day? _____

For how many years? _____ Quit date? _____

Current Medications, Dose and Frequency:

Name:	Dose:	Frequency:

Allergies to Medications/Food:

Name:	Reaction Type:

History of hospitalizations or surgeries:

Date/ Year:	Type of hospitalization/ surgery:

History of any major medical conditions of your immediate family members:

Relation:	Medical condition:

<u>Have you ever received any of the following vaccines?</u>

Pneumonia _____ if yes, which one: Pneumovax Date _____ Prevnar Date _____

Influenza _____ When? _____

Shingles _____ When? _____

Covid _____ When? _____

Patient name: _____ Patient DOB: _____

Please complete the following screening questionnaires to help us assess your mental health and alcohol use.

1. PHQ-2 Depression Screening

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

2. Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

2. AUDIT-C Alcohol Use Screening

Please answer the following questions about your alcohol consumption.

1. How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2–4 times a month ☐ 2–3 times a week ☐ 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

3. How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Consent Forms

A. Consent for Treatment
I hereby give consent to Richmond Pulmonary Medicine to evaluate and treat me.

Signature: _____ Date: _____

B. HIPAA Acknowledgment
I acknowledge that I have received or reviewed a copy of Richmond Pulmonary Medicine's Notice of Privacy Practices.

Signature: _____ Date: _____

C. Financial Policy Agreement
I agree to be financially responsible for all services rendered, including those not covered by insurance.

Signature: _____ Date: _____

Appointment & Cancellation Policy

Please arrive 10 minutes early to your appointment. If you need to cancel, we require 24 hours' notice to avoid a cancellation fee/ No show fee of $50.00.

Initial Here to Acknowledge: _____

Additional Forms

A. Patient Portal User Agreement

This agreement outlines the terms and conditions of use for the Patient Portal provided by our practice. The Patient Portal is intended to provide a secure and convenient method of communication between you and your healthcare provider. Please read and sign to acknowledge your understanding and acceptance.

1. Purpose of the Patient Portal

The Patient Portal is a secure, web-based system that allows you to:
- Access portions of your medical record
- Request appointments and medication refills
- View test results and summaries
- Communicate non-urgent messages with your provider

2. Terms of Use

By using the Patient Portal, you agree to the following terms:
- You will use the Portal for non-urgent communication only.
- In the event of an emergency, you will call 911 or go to the nearest emergency department.
- You will keep your login credentials confidential and notify us immediately if you believe your account has been compromised.
- You understand that all communication via the Portal becomes part of your medical record.
- Access may be terminated at any time at the discretion of your healthcare provider or practice staff.

3. Privacy and Security

We use secure encryption technology to protect your health information. However, it is your responsibility to ensure the privacy of your information when accessing the Portal from your devices. Please log out when finished and do not share your password.

4. Acknowledgment and Consent

By signing this agreement, you acknowledge that you have read, understood, and agree to the terms of use for the Patient Portal

Patient Name: _____
Date of Birth: _____

Email Address (for Portal Access):
_____

Signature: _____ Date: _____

B. Credit Card on File Agreement

Name on Card: _____

Billing Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Credit Card Information

Card Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Card Number: _____

Expiration Date: ____ / ____

CVV: _____

Authorization:

I, [_____], authorize Richmond Pulmonary Medicine PC to charge my credit card for agreed-upon purchases. I understand that my information will be saved on file for future transactions on my account.

I understand that this authorization will remain in effect until I cancel it in writing.

Cardholder Signature:

_____

Date: ____ / ____ / _____

Security & Privacy Notice:

Your credit card information will be securely stored and will only be used as authorized. We do not share your information with any third parties.