

NORTHWEST PULMONOLOGY
NEW PATIENT REGISTRATION



1) Full Legal Name			Previous Last Name
Last	First	M.I.	

2) Gender	Social Security Number	Date of Birth
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Other		
Martial Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

3) Mailing Address			
Street or PO Box	City	State	Zip Code

4) Contact Information (Please check your preferred contact number)			
<input type="checkbox"/> Cell phone	<input type="checkbox"/> Home phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Email

5) Employer			
Name			Phone
Street		City	State Zip Code

6) Preferred Pharmacy			
Name			Phone
Street		City	State Zip Code

7) Emergency Contact		
Name	Relationship	Phone

8) Primary Care Provider		
Name	Address	Phone

9) Referring Provider		
Name	Address	Phone

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10) Guarantor			
Last		First	
		M.I.	
Street or PO Box		City	State
		Zip Code	
SSN		Phone	Relationship to patient

11) Insurance Information			
Primary Insurance Company Name		ID#	Group#
			Phone
Subscriber-Employee Name		SSN	DOB
			Relationship to patient
Secondary Insurance Company Name		ID#	Group#
			Phone
Subscriber-Employee Name		SSN	DOB
			Relationship to patient

12) Demographic Information
<input type="checkbox"/> Decline <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Other

13) Ethnic Information
<input type="checkbox"/> Declined <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino

14) Preferred Language
<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Arabic <input type="checkbox"/> German <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other

I hereby authorize any insurance benefits to be paid directly to Northwest Specialty Hospital. I understand that I am responsible for paying non-covered services. I hereby authorize the release of pertinent medical information to my insurance carriers and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I have verified that demographics information sheet to be true and correct.

 Signature (Patient or Guardian) Date

 Relationship to patient

1) ALLERGIES

MEDICATIONS	
FOOD	
ENVIRONMENT	
HAVE YOU EVER HAD ALLERGY TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ARE YOU ALLERGIC TO LATEX? <input type="checkbox"/> YES <input type="checkbox"/> NO	

2) MEDICATIONS
 Please list all of the medications you are currently taking.

MEDICATION	DOSE	FREQUENCY

3) PAST MEDICAL HISTORY
 DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Numbness of face, arms hands, or legs <input type="checkbox"/> COPD <input type="checkbox"/> Asthma (if yes medication used.) <input type="checkbox"/> Chest pain or shortness of breath. <input type="checkbox"/> Heart disease (murmur or valve prolapse) <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Liver Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Weakness in the Extremities	<input type="checkbox"/> Blood clots <input type="checkbox"/> Cancer (If yes, type) _____ <input type="checkbox"/> Depression/mental illness <input type="checkbox"/> Stroke <input type="checkbox"/> Anemia (low iron in your blood) <input type="checkbox"/> Diabetes <input type="checkbox"/> Major injuries/traumas <input type="checkbox"/> Lung problems <input type="checkbox"/> Emphysema <input type="checkbox"/> Glaucoma <input type="checkbox"/> Sleep Apnea
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4) PAST SURGERIES OR HOSPITALIZATIONS

TYPE:	DATE:
TYPE:	DATE:
TYPE:	DATE:

5) FAMILY HISTORY
 Does anyone in your family have a present or past history of the following:

<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid disorders	<input type="checkbox"/> Strokes	<input type="checkbox"/> COPD
<input type="checkbox"/> Asthma			

6) PERSONAL / SOCIAL HISTORY				
Do you smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many per day?		
How many years?				
Do you consume alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many times per week?		
How many times per month?			How many drinks per time?	
Do you use any illicit drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, what drugs				
Do you feel safe in your current relationship	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Over the past (2) two weeks, how often have you been bothered by any of the following problems:				
	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Have you ever been emotionally or physically abused?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Do you have a support system (i.e., friends/family)?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Date of last eye exam			Date of last dental exam	
Date of your last tetanus injection				

7) REVIEW OF SYSTEMS (LAST SIX MONTHS)	
CONSTITUTIONAL	<input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER <input type="checkbox"/> WEIGHT LOSS _____ LBS <input type="checkbox"/> WEIGHT GAIN _____ LBS
EYES	<input type="checkbox"/> BLURRED VISION <input type="checkbox"/> DOUBLE VISION <input type="checkbox"/> ITCHING <input type="checkbox"/> BURNING <input type="checkbox"/> EYE PAIN
EARS	<input type="checkbox"/> DIFFICULTY HEARING <input type="checkbox"/> EAR PAIN <input type="checkbox"/> VERTIGO <input type="checkbox"/> TINNITUS <input type="checkbox"/> EARS FEEL PRESSURED <input type="checkbox"/> DISCHARGE FROM THE EARS
NOSE	<input type="checkbox"/> FREQUENT NOSEBLEEDS <input type="checkbox"/> NASAL CONGESTION <input type="checkbox"/> CHRONIC RUNNY NOSE <input type="checkbox"/> NOSE/SINUS PRESSURE <input type="checkbox"/> BLOCKAGE/OBSTRUCTION
MOUTH/THROAT	<input type="checkbox"/> SORE THROAT <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> SNORING <input type="checkbox"/> DRY MOUTH <input type="checkbox"/> MOUTH ULCER <input type="checkbox"/> POSTNASAL DRIP <input type="checkbox"/> HOARSENESS
NEUROLOGIC	<input type="checkbox"/> FAINTING FREQUENT <input type="checkbox"/> SEIZURES <input type="checkbox"/> NUMBNESS <input type="checkbox"/> WEAKNESS <input type="checkbox"/> RESTLESS LEGS
CARDIOVASCULAR	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> MURMUR <input type="checkbox"/> IRREGULAR HEARTBEAT <input type="checkbox"/> SWELLING <input type="checkbox"/> LIGHTHEADED ON STANDING
RESPIRATORY	<input type="checkbox"/> WHEEZING <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> COUGHING BLOOD
GENITOURINARY	<input type="checkbox"/> DIFFICULTY URINATING <input type="checkbox"/> PAIN DURING URINATION
GASTROINTESTINAL	<input type="checkbox"/> VOMITING <input type="checkbox"/> PAINFUL SWALLOWING <input type="checkbox"/> DIFFICULTY SWALLOWING
HEM/LYMPH	<input type="checkbox"/> SWOLLEN GLANDS <input type="checkbox"/> EASY BRUISING <input type="checkbox"/> EXCESSIVE BLEEDING
PSYCH	<input type="checkbox"/> DEPRESSION <input type="checkbox"/> ANXIETY
MUSCULOSKELETAL	<input type="checkbox"/> MUSCLE ACHES <input type="checkbox"/> JOINT PAIN
SKIN	<input type="checkbox"/> ITCHING <input type="checkbox"/> RASH <input type="checkbox"/> DRY SKIN <input type="checkbox"/> GROWTHS/LESIONS

7) REVIEW OF SYSTEMS (LAST SIX MONTHS) Contd...	
ENDOCRINE	<input type="checkbox"/> HAIR LOSS <input type="checkbox"/> SENSITIVITY TO HEAT OR COLD
ALLERGY	<input type="checkbox"/> FREQUENT SNEEZING <input type="checkbox"/> RUNNY NOSE
<input type="checkbox"/> OTHER	

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SIGNATURE (PATIENT OR GUARDIAN)

DATE (MM-DD-YYYY)

RELATIONSHIP TO PATIENT

**RELEASE OF INFORMATION
FROM OTHER HEALTHCARE PROVIDERS**



Pulmonology

I, _____, _____, hereby authorize the following providers:
(PATIENT NAME) (DATE OF BIRTH)

LIST ALL PROVIDERS FROM WHOM INFORMATION IS BEING SOUGHT:

PROVIDER	ADDRESS	PHONE	FAX

TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION TO:

Northwest Specialty Hospital
ATTN Medical Records
1551 E Polston Ave
Post Falls, ID 83854
Phone: (208) 262-2300 Fax: (208) 262-2382

INFORMATION TO BE RELEASED: (CHECK ALL THAT ARE APPLICABLE)

- Copies of EKGs taken within the past five years.
- Medical history, including specific progress notes regarding any problems that would impact my surgery or procedure's progress or outcome.
- A list of allergies.
- Results of relevant diagnostic or laboratory tests.
- Entire medical record.
- Other _____

EXCLUDE THE FOLLOWING INFORMATION FROM THE RECORDS RELEASED: (PLEASE INITIAL)

_____ Drug/Alcohol abuse/treatment and diagnosis _____ Sexually transmitted disease
_____ Mental illness or psychiatric diagnosis and treatment _____ HIV/AIDS

This protected health information will be used by the Facility listed above for the purpose of treatment. This authorization shall be in force and effect until _____ (date).
I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the provider(s) listed above.
I understand that a revocation is not effective to the extent that the provider(s) listed above have relied on this form to use or disclose protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy requirements law. However, the Facility is covered by federal privacy requirements and will follow them.
I understand that the provider(s) listed above will not condition treatment, payment, enrollment in a health plan or program, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to refuse to sign this authorization.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

PRINTED OR TYPED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY



ACKNOWLEDGEMENT OF RECEIPT OF LEGAL NOTIFICATIONS



I HAVE been offered/received a copy of legal notifications at Northwest Specialty Hospital which includes the following:

- Patient Rights & Responsibilities
- Privacy Notice
- EMTALA Notification
- Notice of Non-Discrimination & Accessibility Requirements
- Notice of Physician Staffing & Emergency Procedures
- Notice of Physician Ownership
- Financial Assistance
- Your Rights and Protection Against Surprise Billing

NAME (PRINT, FULL LEGAL)

Relationship

SIGNATURE

DATE

ADMINISTRATIVE USE ONLY

Witness

Date



**ACKNOWLEDGMENT OF RECEIPT
OF PRIVACY NOTICE**



I, _____ acknowledge that I have been offered/received a copy of the Privacy Notice.

In addition to our normal operational disclosures of privacy information, please identify to whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the party or parties listed below to request this information:

_____ NAME	_____ RELATIONSHIP
_____ NAME	_____ RELATIONSHIP
_____ NAME	_____ RELATIONSHIP
_____ NAME	_____ RELATIONSHIP

_____ PRINTED PATIENT NAME	_____ SIGNATURE PATIENT OR REPRESENTATIVE	_____ DATE
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For Facility use only:

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

_____ NAME	_____ DATE
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MEDICARE SECONDARY PAYER FORM (MSP)

PART I: Information about Black Lung, Workers' Compensation, No-Fault Liability

1. Are you receiving benefits under the Black Lung Benefits Act? Yes No
 If Yes: Date the benefits began: _____

2. Was this injury/illness due to a work related accident/condition? Yes No
 If Yes: Name and Address of employer: _____
 Name and address of insurance carrier: _____
 Policy or claim number: _____ Date of workplace illness or injury: _____

3. Are you receiving treatment for an injury or illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? Yes No
 If Yes: Name and Address of insurance carrier: _____
 Policy or claim number: _____ Date of workplace illness or injury: _____

4. Are you receiving treatment for an injury or illness, which another party may be liable? Yes No
 If Yes: Name and Address of insurance carrier: _____
 Policy or claim number: _____ Date of illness or injury: _____

PART II: Information about Medicare Entitlement and Group Health Plans

1. Are you entitled to Medicare based on Age Disability ESRD (Skip to Part III)

2. Do you have a group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? Yes No
If No, stop here

3. How many employees, including yourself or spouse, work for the employer from whom you have GHP coverage? (Note: if you are aged and there are 20 or more employees, your GHP is primary. If you are disabled and your employer, spouse or family member employer, has 100 or more employees, your GHP is primary.)
 1-19 20-99 100+

4. The following employer GHP information is required to submit claims appropriately:
 Name and address of employer through which you receive GHP coverage: _____
 Name and address of GHP: _____
 Policy number: _____ Group number: _____
 Date the GHP coverage began: _____
 Name of policyholder (if coverage through spouse/other family): _____
 Relationship to patient (if other than self): _____

PART III: Information about the Patient if ESRD Medicare Entitlement Applies

1. Do you have an employer group health plan (GHP) coverage through yourself, a spouse or family member if dually entitled based on Disability and ESRD? Yes No
If Yes, continue

2. Have you received a kidney transplant? Yes No
 If Yes: Date of transplant: _____

3. Have you received maintenance dialysis treatments? Yes No
 If Yes: Date dialysis began: _____

4. Are you within the 30-month coordination period? Yes No

5. Were you receiving GHP coverage prior to and on the date of Medicare entitlement due to ESRD (or simultaneous entitlement due to ESRD and Age or ESRD and Disability)? Yes No

6. The following information is required to submit claims appropriately:
 Name and address of employer through which you receive GHP coverage: _____
 Name and address of GHP: _____
 Policy number: _____ Group number: _____
 Name of policyholder (if coverage through spouse/other family): _____
 Relationship to patient (if other than self): _____

PRINTED PATIENT NAME _____ SIGNATURE PATIENT OR REPRESENTATIVE _____ DATE _____

PATIENTS GUARDIAN OR REPRESENTATIVE _____ RELATIONSHIP _____ WITNESS _____

