Kwaku Osafo-Mensah, MD
Pulmonary Critical Care and Sleep Medicine
Advanced, personalized care for exceptional outcomes.

PATIENT INFORMATION - PLEASE PRINT

NAME ______________________________ HOME PHONE ____________________________

ADDRESS __________________________ OTHER PHONE ___________________________

CITY, STATE _________________ZIP_________ SOCIAL SECURITY # _______-_______-_______

DATE OF BIRTH ______________ AGE ______ SEX ____ E-MAIL __________________________

RACE __________________ ETHNICITY _______________ LANGUAGE____________________

NAME OF SPOUSE _________________________ SOCIAL SECURITY # _______-_______-_______

CONTACT PH # _______________ DATE OF BIRTH ________________

EMERGENCY NOTIFICATION (OTHER THAN YOUR SPOUSE) NAME ___________________

RELATIONSHIP TO YOU ___________________ HOME PHONE # _____________________

OTHER PHONE # ____________________

REFERRED BY ______________________PHONE # ___________________________

PRIMARY CARE DOCTOR____________________ PHONE # _____________________

DO YOU HAVE INSURANCE? YES ________ NO ________

NAME OF PRIMARY INSURANCE ________________________ PH # ________________________

POLICY # __________________________ GROUP # _____________________

NAME OF SECONDARY INSURANCE _____________________ PH # _______________________

POLICY # ___________________________ GROUP # _____________________

PARTY RESPONSIBLE FOR PAYMENT:

SELF _______ SPOUSE _________ OTHER __________

I UNDERSTAND THAT CO-PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. I REALIZE THAT ALL CHARGES ARE MY RESPONSIBILITY, IF NOT PAID BY MY INSURANCE COMPANY

_______________________________ ___________________

SIGNATURE TODAY'S DATE

PULMONARY CLINIC HEALTH QUESTIONNAIRE

Name: ____________________________ **Date:**________________

Date of Birth:________________

Pulmonary Illness:

Please check all that apply

_______ Asthma

_______Chronic Bronchitis

_______ COPD/Emphysema

_______Cystic Fibrosis

_______Emphysema

_______Lung Cancer

_______Pulmonary Hypertension

_______ Recurrent Pneumonia

_______ Sleep Apnea-CPAP/BIPAP

_______ TB Exposure/History

_______ Other

General Medical Illness:

_______Arthritis

_______ High Cholesterol

_______ Depression

_______ Diabetes

_______ Gallstones

_______ GERD/Reflux

_______ Glaucoma

_______ Gout

_______ Heart Attack

_______ High Blood Pressure

_______ Kidney Stones

_______ Liver Disease

_______Mental Illness

_______Osteoporosis

_______Rheumatic Fever

_______Seizures

_______Lupus

_______Sinus Disease

_______Stomach Ulcers

_______Stroke

_______ Thyroid Disease

Immunizations/Date:

_______ Influenza

_______ Pneumovax

_______ Hepatitis

_______Tetanus

_______ MMR/DPT

_______TB Skin Test (PPD) Pos/Neg

_______ Other

Allergies: check all that apply

_______ None

_______ Animals

_______ Dust Mite

_______ Feathers

_______Foods

_______ Grasses

_______ Insect Bites

_______Pollen

_______ Trees

_______ Other

Allergy to Medications: Yes/No

List all Allergies:

____

____

____

Surgical History and approximate dates

_______ Appendix

_______ Breast

_______ Colon

_______ Gallbladder

_______ Joint /Location

_______ Lung

_______ Spleen

_______ Stomach

_______ Tonsils/Adenoid

_______ Uterus

_______ Other: ____________________

Name:________________________________

Tobacco Use:

Please circle/enter appropriate answer

Current Smoker? Y N

Age Started ________

Packs Per Day ________

Former Smoker ________

Age Quit ________

Packs Per Day ________

E-Cigarette Y N

Cigars? Y N

Pipe? Y N

Smokeless Tobacco? Y N

Smoker in House? Y N

Social History

Occupation: ________________

Marital Status M S W D P

Alcohol Use? Y N

Amount? ________________

Hospitalization:

Have you ever been hospitalized? Y N

For lung disease? Y N

How often? ____________

Placed on a ventilator? Y N

Do you have a living will? Y N

Would you like to be

Placed on life support? Y N

History of drug use Y N

Medical Supplies

Using Oxygen? Y N

Nebulizer Unit Y N

Medical Supply Company

Name: ______________________________

Phone #: ____________________________

Pharmacy Name: ____________________

Pharmacy #:_________________________

Current Medication List: or Provide Copy

______________________ Dosage ________

______________________ Dosage ________

______________________ Dosage ________

______________________ Dosage ________

______________________ Dosage ________

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______________________ Dosage ________

______________________ Dosage ________

______________________ Dosage ________

______________________ Dosage ________

REVIEW OF SYSTEMS: (CIRCLE ANY SYMPTOMS)

CONSTITUTIONAL: Fever, chills, night sweats, fatigue, changes in voice, weight loss/gain

ALLERGY: Seasonal allergies, grass, pollen, dust mites, trees, feathers

EYE: changes in vision, pain, itchiness, yellowish of eye, discharge

ENT: Sore throat, nosebleeds, nasal stuffiness or discharge, sinus problems

ENDOCRINE: Heat intolerance, cold intolerance, frequent urination, frequent thirst, tiredness

RESPIRATORY: Cough, shortness of breath, decreased exercise level, cough up blood, exposure or history of TB, exposure to toxin/chemicals, exposure to secondhand smoke, snore, home oxygen use, CPAP use, nebulizer use

CARDIAC: Chest pain, shortness of breath with activity, short of breath lying down, palpitation, swelling on hands, feet, or whole body

GI: Nausea, vomiting, heartburn or reflux, diarrhea, constipation, black stools, abdominal pain

HEM/LYMPH: Bruising, bleeding problems, recent transfusion, enlarged lymph nodes, spleen removed

GU: Painful urination, frequent urination, blood in urine, need of dialysis, loss of bladder control

MUSCULOSKETAL: Arthritis, joint pain, joint swelling, back pain acute or chronic, muscle cramps or pain, calf or ankle pain

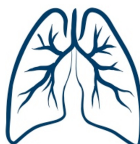
INTEGUMENTARY: Rash, blisters, discoloration of skin, sun sensitivity

NEUROLOGY: Headaches, nervousness, daytime sleepiness, weakness, falls, shakes

PSYCHIATRY: Depression, anxious, suicidal, forgetful, stress, crying a lot, easily irritated

FAMILY HISTORY

CONDITION	FATHER	MOTHER	BROTHER # [ ]	SISTER # [ ]
EMPHYSEMA/COPD				
ASTHMA				
TUBERCULOSIS				
CORONARY ARTERY DISEASE				
HIGH BLOOD PRESSURE				
DIABETES				
GERD				
KIDNEY DISEASE				
HEART ATTACK				
STROKE				
CANCER [TYPE]				
ADVANCED AGE				
OTHER: _______________				
DECEASED (Y OR N)				



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Epworth Sleepiness Scale

Patient Name: ___________________________________

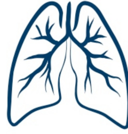
Today's Date: ___________________________________

Patient Age: _________ **Gender:** _________

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. (Even if you have not done some of these things recently, try to work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation:	**Chance of dozing:**
1. Sitting and reading.	_______________
2. Watching television.	_______________
3. Sitting inactive in a public place. (ex: doctor's office)	_______________
4. As a passenger in a car for an hour without a break.	_______________
5. Lying down to rest in the afternoon when possible.	_______________
6. Sitting and talking to someone.	_______________
7. Sitting quietly after lunch without alcohol.	_______________
8. In a car, while stopped for a few minutes in traffic.	_______________
Total Score:	_______________



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EFFECTIVE DATE: OCTOBER 1ST 2012

<u>Cancellation / No Show Policy</u>

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment to avoid a charge of **<u>$25</u>**

I understand if I “no show” for three appointments or cancel for a total of four appointments, I may be discharged from care.

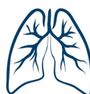
The office will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature

____

Date ________________________________



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Statement of Patient Financial Responsibility

Patient Name: ____ DOB: _______________________

We appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. As such you are responsible for informing us of any insurance updates. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to K. OSAFO. MD. PA, for providing services to me or the above named patient. I certify that the insurance information provided is, true and accurate. I authorize my insurer to pay any benefits directly to K. OSAFO. MD. PA, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ____ Date ___________________________

Guarantor Signature ____Date ___________________________
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ____ Date ____________________________

Consent for Treatment and Authorization to Release Information

I hereby authorize _K. OSAFO. MD. PA, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize _K. OSAFO. MD. PA, to receive/release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature ____ Date ____________________________

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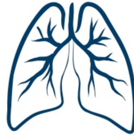
I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature ____ Date ____________________________

Self-Pay

I do not have health insurance and will be responsible for services rendered. I agree to pay _K. OSAFO. MD. PA.
the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature ____ Date ____________________________



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Authorization for Release of Medication Records

Patient Name: ___________________________________ Date of Birth: _________________

Phone Number: ____________________ Last 4 Digits of Social Security #: ______________

I hereby authorize:

SureScripts

To release medication records to:

Practice Name: K. Osafo MD PA Specialty: Pulmonary Disease/Sleep Medicine
Phone Number: 817-348-9015 Fax Number: 817-348-9017

This information is needed for the following reason:

Continuum of Care

The specific information I wish to have released is (include dates of treatment):

ALL MEDICATION RECORDS

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for 365 day period from the date it is signed.

____ ________________________
Signature: (Parent or Legal Guardian if Minor Child) Date:

____
Print Name:

____ ________________________
Witness Signature: Date: