Hunterdon Health

Phone: 908.237.4080
Fax: 908.237.1749

Hunterdon Pulmonary and Critical Care
1121 Route 22 West, Suite 205
Bridgewater, NJ 08807

Authorization to Release Medical Information

Patient's Name: _____ D.O.B. _____

I, _____, give **Hunterdon Pulmonary and Critical Care** permission to release all medical information from my records to the following family members: (*ALL includes test results, medications, and social/family history*).

If the patient is a minor, this form is to give consent to any one else other than parents.

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

_____ _____
Patient / Guardian Date

Date Updated: _____ Initials:

_____

Date Updated: _____ Initials: _____

Date Updated: _____ Initials: _____

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New Patient Outpatient Visit

Date: _____

Patient's Name: _____ Patient's D.O.B.: _____

Referring MD: _____ Pharmacy: _____

Allergies: _____

Reason for visit: _____

_____

Chronic Problems: *(Ongoing Medical Issues)*

O Heart Disease **O** High Cholesterol **O** High Blood Pressure
O Diabetes **O** Environmental Allergies **O** Stroke
O Cancer **O** Acid Reflux **O** Asthma
O Other: _____

Previous Surgeries:

Surgery: _____ Date of Surgery: _____
Surgery: _____ Date of Surgery: _____
Surgery: _____ Date of Surgery: _____
Surgery: _____ Date of Surgery: _____
Surgery: _____ Date of Surgery: _____

Family History: *(Do any diseases below run in your family? If so, please list what relative)*

O Stroke: _____ **O** Environmental Allergies: _____
O Cancer: _____ **O** High Blood Pressure: _____ **O** Acid Reflux: _____
O Seizures: _____ **O** Alpha 1 Deficiency: _____ **O** Diabetes: _____
O COPD: _____ **O** High Cholesterol: _____ **O** Sarcoidosis: _____
O Asthma: _____ **O** Blood Disorder: _____ **O** Sleep Apnea: _____
O Pneumonia: _____ **O** Heart Disease: _____
O Other: _____

Social History:

Occupation: _____ Retired: **O** Yes **O** No
Asbestos or toxin exposure: **O** Yes **O** No
Did you ever smoke: **O** Yes **O** No How long: _____ How much: _____
Do you smoke now: **O** Yes **O** No Quit date: _____
Approximately how many drinks of alcohol do you consume daily: _____
What kind: _____

Review of Symptoms

Mark only symptoms that you have experienced in the last few weeks.
If you have no symptoms, please mark 'NONE'.

Date: _____

Patient's Name: _____ Patient's D.O.B.: _____

General: O **NONE**
O appetite loss O fever
O always tired O chills
O weight loss O sweats

Eyes: O **NONE**
O eye irritation O vision loss
O light sensitivity

Ears/Nose/ Throat: O **NONE**
O decreased hearing O ringing ears
O earache/discharge O sore throat
O nasal congestion O nosebleeds
O hoarseness
O difficulty swallowing

Cardiovascular: O **NONE**
O lightheaded/dizzy O fainting
O trouble breathing at night
O shortness of breath with exertion
O swelling of hands/feet
O chest pain or discomfort
O difficulty breathing when lying down
O leg cramps when walking
O racing/skipping of heartbeat

Respiratory: O **NONE**
O excessive snoring O cough
O coughing up blood O wheezing
O excessive sputum
O shortness of breath
O chest discomfort

Gastro Intest: O **NONE**
O vomiting O nausea
O bloody stools O gas
O constipation O diarrhea
O dark stools O indigestion
O loss of appetite O hemorrhoids
O yellowish skin color
O change in bowel habits

***GI con't):** O **NONE**
O abdominal pain O painful urination
O abdominal bloating

Urology: O **NONE**
O blood in urine
O painful urination O vaginal bleeding
O pelvic pain O lack of sex drive
O inability to control urine

Musculoskeletal: O **NONE**
O gout O back pain
O joint swelling O muscle cramps
O muscle weakness

Skin: O **NONE**
O skin cancer
O rash O itching
O dryness O flushing
O changes in nail beds
O suspicious lesions
O excessive perspiration

Neurologic: O **NONE**
O headache
O numbness O seizure
O tingling O tremors
O memory loss O poor balance
O sensation of room spinning
O excessive daytime sleeping

Psychiatric: O **NONE**
O depression O anxiety

Endocrine: O **NONE**
O excessive thirst
O heat intolerance O cold intolerance
O excessive hunger O excessive urination

Heme/Lymph: O **NONE**
O bleeding
O bruises O swollen glands

Allergic/ Immunology: O **NONE**
O seasonal allergies
O hives/rash
O persistent infections

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"No-Show" Policy

Our practice has a policy to change a **"No-Show"** fee of **$25.00** for a second time that a patient does **NOT** show up for his/her appointment without contacting our office within a reasonable amount of time prior to that appointment.

We appreciate your efforts to be here on time for your appointment and for your understanding the value of the time that has been set aside for YOU, our patient.

Prescriptions

Please ask your physician to refill your medications at the time of your visit. If for some reason you do need a renewal in-between visits, please allow at least **two business days** for your prescriptions to be refilled.

Please do not wait until you are at the end of your prescription to call.

Insurance Cards

We ask that you present your **insurance cards** at **every visit**. If your insurance requires a **referral** to see a specialist, please bring it with you to the visit. **If you do not have your referral on the day of your visit, we may ask you to reschedule your scheduled appointment.**

_____ _____

Patient / Guardian Date

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Dear Patients,

Thank you for choosing Hunterdon Pulmonary and Critical Care to care for your medical pulmonary and critical care needs. We welcome you to our practice, and look forward to caring for you and/or your family member.

Enclosed, please find our informational brochure, containing valuable information about Hunterdon Pulmonary and Critical Care medical staff and services. Also, you will find patient forms that should be completed and presented at your initial office visit to our practice. Included as well, is our reference material identifying the financial policy, patient bill of rights, patient privacy, and safety.

Should you have questions regarding any of our information enclosed, please do not hesitate to contact our office, or discuss any questions with our personnel at your scheduled appointment.

We look forward to providing care for you and/or your family.

Sincerely,

Hunterdon Pulmonary and Critical Care