



912 S. Fleishel | Tyler, TX 75701 | 903-592-6901

Thank you for choosing Pulmonary Specialists of Tyler for your pulmonary needs.

Your appointment is on

MON TUES WED THURS FRI

Date: _____ Arrival Time: _____

PFT Time: _____ CXR Time: _____

You will see _____

Your appointment is scheduled at the following location:

- Tyler Clinic** – 912 S. Fleishel, Tyler.
- Sulphur Springs Allergy Clinic** – 107 Medical Circle, Sulphur Springs.
- Sulphur Springs Clinic** – 107 Medical Circle, Sulphur Springs.
- Jacksonville Clinic** – 2026 Jackson St., Jacksonville.
- Carthage Clinic** – 704 North Davis Street, Carthage.
- Pittsburg Clinic** – 2701 Hwy 271 South (ETMC Pittsburg), Pittsburg
- Athens Clinic** – 117 Medical Circle, Athens

- Please complete all new patient paperwork before arriving for your appointment. Also, bring your New Patient Folder along with your insurance card and driver's license. This will reduce the amount of time spent registering.
- You may receive a phone call prior to your appointment to go over the pink sheet located in the patient packet. This discussion will also reduce the time spent registering.
- On this and every visit, please bring a list of your **MEDICATIONS**, including dosages.
- You will be reminded with a phone call the day before your appointment.
- Failure to cancel your appointment within 24 hours may result in a \$25.00 charge.

We look forward to seeing you. If you have any questions, please contact us at (903) 592-6901 or toll-free at (800) 722-5864.

Sincerely,

Pulmonary Specialists of Tyler, P.A.



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PATIENT REGISTRATION

PLEASE PRINT IN INK

Please put N/A in the blanks that do not apply to you

Patient Information	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Name _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone (____) _____	Student <input type="checkbox"/> N/A <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Work Phone (____) _____	Best hours to contact _____
Cell Phone (____) _____	Email _____
Address _____	SSN _____-_____-_____
City _____ State _____ Zip _____	Date of Birth ____/____/_____
Employer _____ <input type="checkbox"/> Retired	Driver's License # _____
Address _____	State where Driver's License was issued _____
Referring Physician _____	Phone (____) _____
Primary Care Physician _____	Phone (____) _____

Spouse, Parent, Legal Guardian Information	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian
Name _____	Employer _____
Address _____	Work Phone (____) _____
City _____ State _____ Zip _____	Address _____
SSN _____-_____-_____	City _____ State _____ Zip _____
Driver's License # _____	
Emergency Contact	<i>Please be aware that by listing this person, you are giving Pulmonary Specialists of Tyler permission to release your medical information to them in the event of an emergency.</i>
Name _____ Relationship _____	Phone (____) _____

Insurance Information	<i>Please list policyholder if other than the patient. Please list primary company first.</i>
Primary Insurance (Company) _____	Policy # _____
Address _____	Group # _____
Name of Policyholder _____	Relationship to Patient _____
Date of Birth ____/____/_____	SSN _____-_____-_____
Employer _____	Address _____
Secondary Insurance (Company) _____	Policy # _____
Address _____	Group # _____
Name of Policyholder _____	Relationship to Patient _____
Date of Birth ____/____/_____	SSN _____-_____-_____
Employer _____	Address _____

I certify that this information is true and correct.

Name _____ Date _____

**Authorization for Use of Disclosure of Information for
PULMONARY SPECIALISTS OF TYLER, PA (PSOT) AND
TYLER INPATIENT MANAGEMENT SPECIALISTS (TIMS)**

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

I. I, _____, hereby authorize PSOT/TIMS to disclose the following protected information to the following (name of those to receive or disclose additional information pertaining to treatment, payment, and/or health care operations):

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

II. This protected health information may also be used or disclosed for the following purposes:

Information directly related to the financial records of your account. This information may include, but is not limited to, demographic and/or insurance information, date of service, type of service provided, and/or charges (reasons for denial or patient responsibility).

III. This authorization shall be in force until _____ unless PSOT/TIMS receives written notification from me.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the offices of Pulmonary Specialists of Tyler, PA or Tyler Inpatient Management Specialists at 912 South Fleishel, Tyler, TX 75701.

Patient Name (printed)

Patient Date of Birth

Patient Signature / Legal Signature

Date

**PULMONARY SPECIALISTS OF TYLER, PA (PSOT) AND
TYLER INPATIENT MANAGEMENT SPECIALISTS (TIMS)**

Financial Policies

Consent to Pay: In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time the services are rendered. Our providers accept Medicare and many commercial insurance plans. Medicare will forward claims to most secondary payers. If we are contracted providers to your insurance plan, you will be required to pay your co-payment(s)/co-insurance and any unmet deductible at the time of service, as mandated by your insurance company. If we are not a contracted provider, you will be required to pay for your services at the time of service. It is your responsibility to verify with your insurance plan if we are a contracted provider. We accept Visa, MasterCard American Express, and Discover for your convenience. If you have a legitimate hardship, please ask to speak with a patient account representative so we may work with you. _____ (Initials)

I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare, and/or my supplemental policy. I authorize the transfer of credits from one entity to the other to satisfy any outstanding balances. I have read the financial policy and agree to meet my financial obligation in accordance with this policy. _____ (Initials)

Please be advised any outpatient procedures done where the doctor is involved in the actual test, will result in a statement being generated from the hospital as well as the physician's practice. _____ (Initials)

It is your responsibility to provide Pulmonary Specialists of Tyler, PA/Tyler Inpatient Management Specialists with current insurance information on each visit. Without insurance information, you will be responsible to pay for services at the time of the visit. _____ (Initials)

Please note that failure to cancel an appointment within 24 hours may result in a \$25.00 charge.

Patient/Guarantor Name (printed)

Patient/Guarantor Date of Birth

Patient/Guarantor Signature

Date



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Name _____ Date _____

Referring Doctor _____

What is your main problem that we may help with? _____

List all medications you are taking and how you take them (even over the counter): _____

Are you allergic to any medications? _____

Have you ever had: Asthma Emphysema Diabetes High blood pressure Heart disease Cystic fibrosis Cancer

List any other illnesses and all surgeries: _____

List age and cause of death of each immediate family member: _____

Circle diseases that run in your family: Asthma Emphysema Diabetes High blood pressure Heart disease Cystic fibrosis

What is/was your occupation? _____

Any fume/dust/asbestos exposure? _____

Do you or have you ever smoked? _____ For how long? _____ Packs per day _____ Date stopped _____

Do you or have you ever consumed alcohol? _____ If so, what type and how much per day? _____

List any pets or animals you have: _____

List any recent out of state travel: _____

FOR NURSE USE ONLY

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS IF THEY HAVE BEEN SIGNIFICANT:

- Fever (100 degrees or greater) Blurry/double vision Severe headache Ear pain/congestion
- Nose bleeding Sore throat Coughing up blood
- Chest pain on exertion Ankle/leg swelling Blood in stool Vomiting blood Swollen lymph nodes
- Muscle aches/pains New skin rash Tension Depression Anxiety
- Sleep problems Indigestion/heartburn

BP _____ HR _____ RR _____ Temp _____ O2 saturation _____

Age _____ Weight _____ Height _____ CXR _____

**PULMONARY SPECIALISTS OF TYLER, PA (PSOT) AND
TYLER INPATIENT MANAGEMENT SPECIALISTS (TIMS)
*Notice to the Parents or Legal Guardians of a Minor***

If your child is a minor, you **must** be present at your child's **initial visit** to sign the parental consent form below and provide your child's social security number. The consent form you sign gives the physicians and staff of Pulmonary Specialists of Tyler, PA permission to treat your child. Without a signed consent form, we cannot legally treat a minor child.

If you are not the parent, but are the **legal guardian**, you will need to provide legal documentation that you are the legal guardian. This information will be kept in the child's file.

CONSENT TO TREAT MINOR

I authorize Pulmonary Specialists of Tyler, PA to treat and provide any healthcare services to my child that the provider deems necessary for treatment and/or diagnosis including biopsies. I also understand, in the course of treatment, photographs may be taken for clinical, commercial, or educational purposes.

Unaccompanied Minors

I grant permission to treat and provide any healthcare services to my child that the provider deems necessary for treatment if my child arrives at the office unaccompanied. Agreed to _____

Minor Accompanied by Others

If I am unable to accompany my child to the appointment, the below listed individuals have my permission to accompany my child. This agreement is required in order for the unaccompanied child to be seen and treated. Agreed to _____

I further acknowledge this consent will remain in effect until either I revoke, in writing and delivered to you, or the minor reaches the age of 18 years.

Patient Name

Date of Birth

Parent/Legal Guardian Signature

Date

Witness Signature

Date

Parent/Legal Guardian Information

Name _____

SSN _____

Date of Birth _____

Relationship _____

Work # _____

Cell # _____

Home # _____

Name _____

SSN _____

Date of Birth _____

Relationship _____

Work # _____

Cell # _____

Home # _____

Other Individuals Allowed to Accompany My Child

Name _____

Relationship to Patient _____

Name _____

Relationship to Patient _____

Name _____

Relationship to Patient _____



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The Epworth Sleepiness Scale

Name: _____ DOB: _____

Today's Date: _____

Your Age (Years): _____

Male = M; Female = F : _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 change of dozing
- 3 = high chance of dozing

- Sitting and reading _____
- Watching TV _____
- Sitting, inactive in a public place _____
- As a passenger in a car for an hour without a break _____
- Lying down to rest in the afternoon _____
- Sitting and talking to someone _____
- Sitting quietly after a lunch without alcohol _____
- In a car, while stopped for a few minutes in traffic _____



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SLEEP DISORDER QUESTIONNAIRE

NAME: _____ DOB: _____

1. During the week, what time do you normally go to bed? _____
2. During the week, what time do you normally wake up? _____
3. On your weekends, or during your time off, do you sleep more than you do during the week? _____

4. Do you have memory lapses? _____
5. Do you have difficulty concentrating? _____
6. Do you find that you are sleepy all the time? _____
7. Do you fall asleep when you are trying to watch television, read a book, or perform other tasks?

8. Do you have trouble falling asleep? _____
9. Do you nap during the day? _____
10. If so, how many times do you nap and for how long? _____
11. Do you drink alcohol, and if so how much? _____
12. Do you consume foods with caffeine (soft drinks, tea, coffee, chocolate)? If so, how much? _____

13. Do you use tobacco? If so, how much? _____
14. Do you feel there is undue stress in your life now? _____
15. Do you exercise close to bedtime or perform tasks requiring a lot of mental concentration before
bedtime? _____
16. Do you snore? _____
17. Have you been told by a bed partner that you stop breathing during sleep? _____
18. Have you been told by a bed partner that you move your legs about or kick excessively during
sleep? _____
19. Do you have cramping, pulling, or other disagreeable sensations in your legs when relaxing or
trying to sleep? _____
20. Have you experienced any weakness in the legs during periods of excitement or stress? _____
