

Martha Jefferson Medical Group

Please print and complete this form and bring it with you to your first appointment.

Patient Information (Name must match insurance information if applicable)

Last Name:		First Name:		MI:
Previous Name:		Primary Care Physician:		
Address Line 1:		Address Line 2:		
City:		State:	Zip:	
Home Phone:	Cell Phone:	Work Phone:		
Date of Birth	Sex: M F	Marital Status: Circle one M S W D	SSN: / /	

Who is responsible for paying the bill? (if different from above)

Name (Last, First, Middle):		DOB: / /	
Street Address:			
City:		State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Sex: <input type="radio"/> Male <input type="radio"/> Female		SSN: / /	

Emergency Contact Information (if different from responsible party)

Name:	Relationship to Patient: <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Other		
Street Address:			
City:		State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	

Insurance Subscriber: [Please provide a copy of your insurance card(s).] If same as patient, skip this section.

Name (Last, First, MI):		DOB: / /		SSN: / /	
Street Address:					
City:		State:	Zip:		
Home Phone:	Cell Phone:	Work Phone:			
Sex: <input type="radio"/> Male <input type="radio"/> Female					
Relationship to Patient: <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Other (please specify)					

Martha Jefferson Medical Group

Patient Name:	DOB: / /
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Employment Information:

Employment Status: <input type="radio"/> Employed <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="radio"/> Unemployed <input type="radio"/> Retired		
Employer Name:	Phone:	
Street Address:		
City:	State:	Zip:

Pharmacy Information

Preferred Pharmacy Name and Address:
Preferred Mail Order Pharmacy:

Minor (under age 18) or Guardianship Info: Who has legal responsibility for the patient?

If required, please provide a copy of your guardianship or custody agreement.

Name:	Phone:	
Relationship to Patient: <input type="radio"/> Parent <input type="radio"/> Spouse <input type="radio"/> Guardian <input type="radio"/> Other (please specify)		
Street Address:		
City:	State:	Zip:
Who is authorized to bring the patient in for treatment?		

Release of Information

Is it OK to leave message on: home work cell phone? (check all that apply)

To whom can we release information about the patient?

Name:
Relationship to patient:
Name:
Relationship to Patient:
Name:
Relationship to Patient:

Other Information to improve services and quality of care for all patients

Race: <input type="radio"/> Asian <input type="radio"/> White <input type="radio"/> African American <input type="radio"/> Other _____ <input type="radio"/> No Answer (please specify)
Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> No Answer
Preferred Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____ <input type="radio"/> No Answer (please specify)

I certify that the information I have given above is true and accurate.

Patient's relationship to signer: Patient Spouse Parent Child Guardian Other _____
 Patient is unable to sign or acknowledge

Printed Name

Signature

Date

Martha Jefferson Medical Group

Financial Policy

Martha Jefferson Medical Group (MJMG) is committed to providing each patient with the best possible medical care. The following information is provided to avoid any misunderstanding concerning payment for the professional services rendered by our practice.

We currently accept all of the following methods of payment:

- | | |
|-----------------|-------------------------------------|
| 1.) Cash | 5.) Discover |
| 2.) Check* | 6.) American Express |
| 3.) Visa | 7.) Debit Card |
| 4.) Master Card | 8.) Travelers Check (with photo ID) |

* Please note returned checks are subject to a \$25.00 fee.

Insured Patients:

- Any required co-payments will be collected at the time of service.
- A \$10.00 statement processing fee will be assessed to an account if payment is not made at the time of service.
- Upon receipt of a statement from our billing office, you will be responsible to pay any billed amounts unless other arrangements have been made.
- If your insurance plan determines a service not to be covered, we may bill you for that charge.
- If we do not have a contract with your insurance carrier, we will bill your insurance plan on your behalf.

Self Pay Patients:

- A \$50 deposit is due at the time of service.
- If you need financial assistance, please ask the receptionist for payment options.

MJMG requests 24 hours cancellation notice for all appointments. For no advance notification, a \$25.00 "No Show" fee may be charged for each appointment missed.

Thank you for the opportunity to serve you. If you have questions regarding this information, please do not hesitate to ask. We are here to assist in any way we can.

RESPIRATORY QUESTIONNAIRE

Name: _____ Date of Appt.: _____ Age: _____

Referring MD: _____

Preferred Pharmacy, name and location: _____

Primary Care Physician name and location: _____

Occupational History: Please list entire work history, starting with present job and going back to first job.

Occupation/Job Title	From	To	Specify Type of Work

Number of Years

- | | | | |
|---|-----|----|-------|
| A. Have you ever worked in a dusty job? | Yes | No | _____ |
| 1. In a mine? | Yes | No | _____ |
| 2. In a quarry? | Yes | No | _____ |
| 3. In a foundry? | Yes | No | _____ |
| 4. In a pottery? | Yes | No | _____ |
| 5. In a cotton, flax, or hemp mill? | Yes | No | _____ |
| 6. With Asbestos? | Yes | No | _____ |
| 7. In a brick plant? | Yes | No | _____ |
| 8. As a sandblaster? | Yes | No | _____ |
| 9. In the manufacture of glass,
ceramics, or abrasives | Yes | No | _____ |
| 10. In other dusty jobs:
Please specify _____ | Yes | No | _____ |
| B. Have you ever worked with chemicals? | Yes | No | _____ |

II. Previous Illnesses

- | | | | |
|--|-----|----|--|
| A. Have you ever had any of the following problems? | | | |
| 1. Asthma? | Yes | No | |
| 2. Emphysema? | Yes | No | |
| 3. Chronic bronchitis? | Yes | No | |
| 4. Pneumonia? | Yes | No | |
| 5. Tuberculosis? | Yes | No | |
| 6. Pleurisy? | Yes | No | |
| B. Have you ever had surgery on your chest or lungs? | Yes | No | |
| If yes, specify _____ | | | |
| C. Chest x-ray Last One (date) _____ | Yes | No | |
| Ever abnormal? | Yes | No | |
| D. Tuberculosis skin test | Yes | No | |
| Last one (date) _____ | | | |
| Positive? | Yes | No | |

III. Symptoms

- | | | | |
|---|-----|----|--|
| A. <u>Cough</u> | | | |
| 1. Do you usually cough first thing in the morning? | Yes | No | |
| 2. Do you usually cough at other times during the day or night? | Yes | No | |
| <i>(Skip 3 to 6 if answer to 1 and 2 is "No.")</i> | | | |
| 3. Do you cough on most days for as much as 3 months of the year? | Yes | No | |
| 4. For how many years have you had this cough? | | | |
| Less than 2 years _____ 2 to 5 years _____ 5 years or more _____ | | | |
| 5. Do you cough more on any particular day of the week? | Yes | No | |
| If yes, which day? _____ | | | |
| 6. Do you cough during any particular season of the year? | Yes | No | |
| If yes, which season? _____ | | | |

B. Sputum

1. Do you usually bring up phlegm, sputum or mucus from your chest first thing in the morning? Yes No
2. Do you usually bring up phlegm, sputum, or mucus from your chest at other times of the day or night? Yes No

(Skip 3 and 4 if the answer to 1 and 2 is "No.")

3. Do you bring up phlegm, sputum, or mucus from your chest on most days for as much as 3 months of the year? Yes No
4. For how many years have you raised phlegm, sputum or mucus from your chest?
 Less than 2 years _____
 2 to 5 years _____
 5 years or more _____

C. Wheezing

1. Does your breathing ever sound wheezy? Yes No
2. Have you ever had attacks of shortness of breath with wheezing? Yes No
3. Have you ever had a feeling of tightness in your chest? Yes No

(Skip 4 to 6 is answer to 1,2, and 3 is "No.")

4. At what age did wheezing first occur? _____
5. How frequently does wheezing occur?
 Daily _____ Nightly _____ A few times per week _____
 A few times per month _____ A few times per year _____

D. Breathlessness

1. Do you get short of breath when walking on ground level? Yes No
2. Do you get short of breath while walking up stairs? Yes No
3. How many flights of stairs can you climb up without stopping?
 1 to 2? _____ 2 to 3? _____ More than 3? _____

E. Hemoptysis

1. Have you ever coughed up blood from your chest? Yes No
 If yes when was the last time this happened?

IV Smoking

A. Smoking (formerly)

1. Have you ever smoked regularly? Yes No
- (Skip 2 to 7 if answer to 1 is "No." Answer if "Yes.")*
2. How old were you when you started smoking? _____
3. For how many years did you smoke regularly? _____
4. When did you quit smoking? Month _____ Year _____

V. Alcohol (currently)

1. Do you currently consume alcohol? Yes No
- (Skip if answer to 1 is "No". Answer if "Yes")*
2. How much alcohol daily do you consume? _____

VI. Travel

1. Have you traveled anywhere within the last year? Yes No
 If yes please list dates and location _____

VII. Hobbies

Please list hobbies and interests _____

VIII. Pets

1. Do you have pets inside? Yes No
 If yes, please list _____

IX. Vaccines

Last Flu Shot _____
 Last Pneumonia Shot _____

PERSONAL HISTORY: Please Circle

Pneumonia	No	Yes	Hives or Eczema	No	Yes
Influenza	No	Yes	Frequent Infections/Boils	No	Yes
Pleurisy	No	Yes	AIDS	No	Yes
Rheumatic Fever	No	Yes	Gallbladder disease	No	Yes
Heart Disease	No	Yes	Anemia	No	Yes
Arthritis/Rheumatism	No	Yes	Jaundice	No	Yes
Any bone or joint disease	No	Yes	Bladder disease	No	Yes
Epilepsy	No	Yes	Nausea or vomiting	No	Yes
Migraine headaches	No	Yes	Abdominal Cramping	No	Yes
Diabetes	No	Yes	Any blood in BM	No	Yes
Cancer	No	Yes	Rectal pain with BM	No	Yes
High/Low Blood Pressure	No	Yes	Change in size, shape, color or texture of BM	No	Yes
Fainting spells	No	Yes	Hemorrhoids/rectal disease	No	Yes
Dizziness on change of position	No	Yes	Colitis/other bowel disease	No	Yes
Unconscious spells	No	Yes	Pain on urination	No	Yes
Blurred/Double Vision	No	Yes	Difficulty in starting urination	No	Yes
Any changes in vision	No	Yes	Getting up at night to urinate	No	Yes
Do you wear glasses	No	Yes	How many times _____		
Date of last exam _____			Any blood in urine	No	Yes
Earaches	No	Yes	Recurrent back pain	No	Yes
Ringing in ears	No	Yes	Backaches	No	Yes
Decrease in hearing	No	Yes	Tingling/weakness hands/feet	No	Yes
Recurrent Nose bleeds	No	Yes	Joint pains	No	Yes
Sinus trouble	No	Yes	Swelling of any joints, ankles, hands or feet	No	Yes
Hay fever/Asthma	No	Yes	Redness/heat of any joints	No	Yes
Persistent Hoarseness	No	Yes	Loss/change in sensation of hands/feet	No	Yes
Difficulty swallowing	No	Yes	Hot flashes	No	Yes
Enlarged glands	No	Yes	Inability to stand cold	No	Yes
Recurrent sores in mouth	No	Yes	Easy bruising	No	Yes
Soreness /bleeding when brushing	No	Yes	Any skin rash	No	Yes
Chest pain	No	Yes	Brittleness of nails	No	Yes
Angina pectoris	No	Yes	Dryness of Skin	No	Yes
Pain in arm(s)	No	Yes	Growth in neck or throat	No	Yes
Night Sweats	No	Yes	Palpitations or fluttering heart	No	Yes
Wake up at night short of breath	No	Yes	Belching or heartburn	No	Yes
Recurrent stomach pains	No	Yes	Relieved by food or medication	No	Yes
Appetite Good____Fair____Poor_____			Snoring	No	Yes
How many bed pillows do you use _____			Morning Headaches	No	Yes
			Daytime Sleepiness	No	Yes

If you have *asthma*, over the last 4 weeks:

1. How often did it prevent you from getting as much done as you wanted? _____
2. How often were you short of breath? _____
3. How often did you use albuterol? _____
4. How often did you have nighttime symptoms? _____
5. On a scale of 1 to 5, how would you rate your asthma control? _____

EPWORTH SLEEPINESS SCALE

(please circle chance of dozing in the following situations)

<u>Situation</u>	<u>Chance of Dozing</u>			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (theater or meeting)	0	1	2	3
As a passenger in a car for an hour	0	1	2	3
Lying down to rest during the day	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

TOTAL: _____

FAMILY HISTORY

	Age	Medical Conditions
Father		
Mother		
Siblings (circle one)		
Sister Brother		
Sister Brother		
Sister Brother		
Children		
Son Daughter		
Son Daughter		
Son Daughter		
Son Daughter		

Has any blood relative ever had: (Please circle and give relationship.)

Cancer (and type): _____ Diabetes: _____ Stroke: _____
 TB: _____ Heart Disease: _____ High blood pressure: _____
 COPD: _____ Liver Disease: _____ Asthma: _____

SURGICAL HISTORY

Surgery type	Year

ADDITIONAL INFORMATION:
