Pinehurst Medical Clinic

Location: «ApptLocDesc»
Pinehurst Medical Clinic Pulmonology - Pinehurst
205 Page Road, Pinehurst, NC 28374

RE: Appointment Date: «ApptDate»
Appointment Time: «ApptTime»
Provider: «ApptResName»

«PFirst» «PLast»
«PStreet1»
«PCity», «PState» «PZipCode»

Dear «PFirst» «PLast»,

We are pleased to welcome you as a new patient of Pinehurst Medical Clinic Pulmonology - Pinehurst. To ensure the best possible experience during your upcoming visit, please take note of the following:

1. Plan on arriving at least 15 minutes prior to the scheduled time of your appointment to avoid delays.
2. Bring your medical insurance card(s) and medications with you on the day of your appointment. To find a list of PMC's contracted payers or to review additional insurance information, please visit pinehurstmedical.com/resources-category/insurance
3. If previous medical records are needed our office may contact you to make arrangements to obtain records.
4. If you are a new patient being seen for pulmonology issues and have had any recent testing or imaging done **outside the FirstHealth system**, please bring copies of those records and the CD discs of the imaging to your appointment. *If you are being referred to us for an abnormal CT scan, you **must** bring a copy of the CT scan on a CD disc.*
5. Once you've established care, for urgent needs after hours, please call the office and follow the instructions to reach the provider on call.

*Pinehurst Medical Clinic Pulmonology & Sleep Medicine kindly ask you and anyone coming with you to your appointment to **refrain** from wearing scented lotions, perfumes, and/or cologne as many of our patients are sensitive to these products. If you or any persons with you do not adhere to this policy, you may be asked to reschedule.*

We look forward to seeing you soon. In the event you need to cancel your appointment, we ask that you give us at least 24 hours' notice.

Sincerely,
PMC Pulmonology
(910) 295-9359

Pinehurst Medical Clinic

REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone:		
Mobile Phone:	**Other Phone:**	
Patient e-mail:		
Date of Birth:	**Sex:** □ Male □ Female	
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Unknown		
Race: □ Black/African American □ Asian □ White □ American Indian/Alaskan Native □ Native Hawaiian/Other Pacific Islander □ Unknown		
Ethnicity: □ Hispanic □ Non-Hispanic		
Primary Language: □ English □ Spanish □ Other: _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: □ Employed □ Self-employed □ Retired □ Disabled □ Student □ Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	**State:**	**Zip Code:**
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	**Effective Date – From:**
Subscriber Name:	**Patient's Relationship to Insured:**
Subscriber SSN:	**Subscriber's DOB:**
Subscriber Employer:	**Subscriber's Sex:** □ Male □ Female

Pinehurst Medical Clinic
PULMONOLOGY

NEW PATIENT QUESTIONAIRE

Pulmonary & Sleep Medicine

Date:_____

Patient Name: _____Date of Birth: _____

Referring Provider: _____

Primary Care Provider: _____

☐You are scheduled for a Pulmonary (Lung) issue with_____

☐You are scheduled for a Sleep Medicine issue with_____

What is your main lung or sleep problem?

_____

Marital status: Single Married Divorced Widow

Occupation:_____**Retired**: ☐

Education Level: _____

Leisure Activities – Hobbies: _____

_____

Medical History:

Please list current medical conditions or past illnesses ***you*** are being/have been treated for:

☐ ***I have no current diagnosed medical conditions***

☐High blood pressure	☐Diabetes	☐High Cholesterol
☐Chest pain/heart attacks	☐A-fib/Flutter	☐Congestive Heart Failure
☐Heart Valve Ds/Murmur	☐Stroke	☐Peripheral Vascular Disease
☐Pulmonary Fibrosis	☐Asthma	☐COPD ☐Emphysema
☐Pulmonary Hypertension	☐Blood Clots	☐Cancer: _____
☐Sarcoidosis	☐Heartburn/reflux	☐Allergies/Hay fever
☐Pneumonia	☐Sinus Infections	☐Ear Infections ☐Tuberculosis (TB)

☐Previously diagnosed with Sleep Apnea ☐ COVID-19

☐ If you have Sleep Apnea, are you currently using a CPAP machine? _____

Other conditions:

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

Surgical History: Please list any operations ***you*** have had.

☐ ***I have never had any surgeries***

☐ Gall Bladder ☐Appendix ☐Tonsils ☐Ear Tubes

☐ Heart Bypass ☐Heart Valve ☐Pacemaker/Defibrillator ☐Vascular Surgery

☐ Back ☐Hip ☐Knee ☐Shoulder

☐ Lung biopsy ☐Lung Removal ☐Bronchoscopy

Other Surgeries:

1. _____ 3. _____
2. _____ 4. _____
5. _____ 6. _____

Family History: Please check if any close ***family members*** have any of the following:

☐ Cancer ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Lung problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Heart Problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Blood Clot Problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Sleep Problems ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ High Blood Pressure ☐Father ☐Mother ☐Siblings ☐Kids _____

☐ Diabetes ☐Father ☐Mother ☐Siblings ☐Kids _____

Other Problems?_____Who/What: _____

Medications you are currently taking & drug dosage/frequency of each: Please include any Over-the-Counter meds.

☐ ***I'm currently not taking any prescribed medications***

☐ Albuterol (Proair, Proventil, Ventolin, Xopenex) ☐Atrovent ☐Combivent

☐ Flovent ☐Arnuity ☐Asmanex ☐Pulmicort ☐Qvar ☐Alvesco ☐Aerospan

☐ Advair ☐Breo ☐Symbicort ☐Dulera ☐ Nebulizer: _____

☐ Serevent ☐ Striverdi ☐ Arcapta ☐ Spiriva ☐ Incruse ☐ Tudorza ☐ Seebri

☐ Anoro ☐ Stiolto ☐ Bevespi ☐ Utibron ☐ Singulair ☐ Daliresp ☐ Prednisone

☐ Theophyline ☐Flonase/Nasonex ☐Claritin/Zyrtec/Allegra ☐Omeprazole/Nexium/Prilosec

Others:

1. _____ 10. _____
2. _____ 11. _____
3. _____ 12. _____
4. _____ 13. _____
5. _____ 14. _____
6. _____ 15. _____
7. _____ 16. _____
8. _____ 17. _____
9. _____ 18. _____

Allergies to Medications:
☐ I have no known allergies to medications

1. _____ 3. _____
2. _____ 4. _____

Vaccinations: last given?
☐ Flu Shot: _____
☐ COVID-19: _____
☐ Pneumonia: ☐ Pneumovax (23): _____ ☐ Prevnar (13): _____

Social History
Smoking Status:
☐ Never
☐ Years Smoked:_____Age started___Packs per day: _____
☐ Date Quit_____/_____months/years ago
☐ Lived with someone who smoked: #Years_____
Alcohol consumption: ☐None ☐Drinks per day:_____ Week:_____
Caffeine consumption: ☐None ☐Drinks per day:_____ Week: _____

Occupational History: Have you ever worked around or been exposed to the following:
☐ Asbestos: ☐ Silica or Coal dust ☐Furniture/Saw Mills
☐ Cotton or Textile Mills: ☐Welding fumes
☐ Toxic/Industrial Chemicals: _____
☐ Someone with ACTIVE tuberculosis "TB"

Current Pets: ☐Cats ☐Dogs ☐Birds ☐Other:_____

Please mark any symptoms you are having now or in the "recent" past.

General Health ☐No Symptoms
☐ Fever ☐ Malaise/no energy ☐No appetite
☐ Shaking chills ☐Fatigue ☐Drenching night Sweats
☐ Recent weight Loss

Ear Nose & Throat: ☐No Symptoms
☐ Sore throat ☐Nasal congestion ☐Ear ache
☐ Scratchy throat ☐Nasal discharge ☐Loss of hearing
☐ Hoarseness ☐Sneezing ☐White patches in mouth
☐ Nosebleeds ☐Snoring ☐Sinus pain
☐ Visual changes ☐Eye symptoms ☐Stop breathing in sleep

Cardiovascular: ☐No Symptoms
☐ Chest Pain ☐Racing heart ☐Leg Edema
☐ Palpitations ☐Light headedness

Pulmonary: ☐**No Symptoms**

☐ Short of breath (SOB)	☐Cough	☐Clear sputum
☐ Wheeze	☐Dry cough	☐Colored sputum
☐ Productive cough	☐Coughing up blood	☐SOB worse lying down
☐ Unable to cough up sputum	☐Coughing when eating	☐Chest pain with breathing
☐ Sleeping upright/Extra pillows	☐Awakening at night SOB	

Gastrointestinal - Stomach & Bowels: ☐**No Symptoms**

☐ Abdominal Pain	☐Nausea	☐Constipation
☐ Abdominal bloating	☐Vomiting	☐Bright Red Blood per Rectum
☐ Abdominal cramps	☐Diarrhea	☐Melena/black-sticky stool
☐ Menstrual pain	☐Heartburn	☐Vomiting blood
☐ Unable to pass flatus		

Urinary: ☐**No Symptoms**

☐ Painful urination	☐Suprapubic pain
☐ Urinary frequency	☐Pelvic pain
☐ Urinary urgency	☐Dark urine
☐ Flank pain	☐Blood in urine

Female Specific

☐Foul smelling vaginal d/c
☐Missed menstrual period
☐Suspected pregnancy
☐Menstrual pain

Male Specific

☐Urinary incontinence
☐Urinary hesitancy
☐Nocturia
☐Testicular pain

Musculoskeletal: ☐**No Symptoms**

☐ Diffuse joint pain	☐Joint swelling	☐Pain in other joints
☐ Muscle ache generalized	☐Joint stiffness	☐Limping
☐ Back pain	☐Back muscle spasm	

Skin & Breasts: ☐**No Symptoms**

☐ Rash	☐Erythema	☐Nodule
☐ Lesions	☐Edema	☐Plaque
☐ Wound	☐Scaling	☐Papule
☐ Itching	☐Blister	☐Pustule
☐ Ulcer	☐Breast pain	☐Pain w/o rash or sore
☐ Mouth sores	☐Patch	☐Breast lump

Neurologic: ☐**No Symptoms**

☐ Headache	☐ Paresthesia/pins & needles	☐ Leg Weakness	☐ Fainting
☐ Confusion	☐ Saddle paresthesia	☐ Tingling	
☐ Dizziness	☐Leg numbness	☐Difficulty walking	

IMPORTANT

If you've had **CT Scans** and/or **Chest X-rays** please bring the CD-ROM disk to your appointment.

You will not need the disk if you had these done at the following:

FirstHealth of the Carolina – all hospitals and clinic locations

Pinehurst Surgical Clinic

Scotland Memorial Hospital

Valley Regional Imaging

Pinehurst Medical Clinic

Sleep Questionnaire

Do you snore? ☐Yes ☐No ☐Don't know

If yes, is it loud? ☐Yes ☐No ☐Don't know

How long ago did it start?_____

months/yearsIs it worsening? ☐Yes ☐No

☐Don't know

In which positions do you snore? ☐ Back only ☐ All positions

Is your snoring worse on your back? ☐ Yes ☐No ☐ Don't know

Do you snore if you fall asleep in a chair? ☐ Yes ☐No ☐ Don't know

Does your snoring disturb anyone? ☐ Yes ☐No Who? _____

Has anyone ever noticed if you stop breathing in your sleep? ☐Yes ☐No

Do you ever wake yourself from sleep with your snoring, gasps or feeling choked? ☐Yes ☐No

Do you suffer from either of the following in the morning? ☐Dry mouth ☐Headaches ☐Neither

Do you feel sleepy during the daytime? ☐Yes ☐No

If yes, how many days per week? _____

When did it start?_____months/years

Is it worsening? ☐Yes ☐No ☐ Don't know

Have you ever felt sudden loss of strength in response to emotional experiences? ☐Yes ☐No

Have you ever felt paralyzed when you first wake up or when falling asleep? ☐Yes ☐No

Have you ever had vivid or menacing visions just before falling asleep? ☐Yes ☐No

Do you walk in your sleep? ☐Yes ☐No ☐Don't know

Do you talk in your sleep? ☐Yes ☐No ☐Don't know

Do you have nightmares? ☐Yes ☐No

Do you ever accidentally urinate in bed? ☐Yes ☐No

What time do you generally go to bed?_____pm/am Wake up?_____am/pm

How long does it usually take for you to fall asleep?_____minutes?_____hours?

How many times do you wake up in the middle of the night? _____

Are you able to fall back to sleep easily after these night awakenings? ☐Yes ☐No ☐Not always

EPWORTH Sleepiness Scale: Please rate your ***chance of dozing*** in following situations.

0 – NEVER dose

1 – SLIGHT chance

2 – MODERATE chance

3 – HIGH chance

___ Sitting & reading

___ Watching TV

___ Sitting inactive in public

___ Passenger in a car w/o break

___ Laying down to rest in afternoon

___ Sitting & talking to someone

___ Sitting quietly after lunch w/o alcohol

___ In a car, stopped in traffic for a few minutes

Have you ever had a traffic accident or "close call" while driving because of sleepiness?

☐Yes ☐No

Do you suffer from memory problems? ☐Yes ☐No

Do you take any daytime naps? ☐Yes ☐No

How many per week?_____How long do you nap on average?_____Minutes

Are the naps refreshing? ☐Yes ☐No

Rate the severity of your daytime sleepiness on a scale of 1 to 10. _____

Do you ever experience restlessness or discomfort in your legs, especially in theevenings? ☐Yes ☐No

Does it interfere with sleep? ☐Yes ☐No

Do you move or kick your legs while sleeping? ☐Yes ☐No ☐ don't know

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IMPORTANT

If you had a **Sleep Study** at another facility, **please bring copies of the study** with youor have reports faxed to:

Fayetteville (910) 420-1618 Pinehurst (910) 235-3401 Sanford (919) 292-1205

Pinehurst Medical Clinic

Pinehurst Medical Clinic Consent for Release of Protected Health Information to Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Check all that apply:

- ☐ All of my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) to pick up or arrange for medical equipment to be provided to me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient at Pinehurst Medical Clinic, unless and until I notify Pinehurst Medical Clinic in writing of any changes.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to patient: _____

Pinehurst Medical Clinic

Account #_____

Patient Acknowledgment and Authorization

Please initial each section and sign to indicate acknowledgment and authorization.

_____ **Patient Payment Policy**
I have read and understand the Pinehurst Medical Clinic, Inc. Patient Payment Policy and I agree to pay for treatment rendered to me/the patient.

_____ **Notice of Privacy Practices**
I understand that Pinehurst Medical Clinic, Inc. will use and disclose my/the patient's health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

_____ **Assignment of Insurance Benefits**
I authorize the payment of medical benefits to Pinehurst Medical Clinic, Inc., and hereby assign to Pinehurst Medical Clinic, Inc. and the professionals involved in my/the patients care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for the services provided to me/the patient.

_____ **Consent to Treat**
I, the Patient/the Patient's Legal Representative, hereby grant permission to Pinehurst Medical Clinic, Inc., and its authorized representatives to perform examinations/treatment deemed necessary or advisable for diagnosis and treatment.

_____ **Patient Rights and Responsibilities**
I understand that I have the right, and the responsibility, to participate in my/the patient's care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my/the patient's health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that the Pinehurst Medical Clinic health care providers will treat me with respect,
and I agree to do the same for them.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Pinehurst Medical Clinic

Pinehurst Medical Clinic Patient Payment Policy

1. Payment is due at the time of service. This may include deductibles, co-payments, co-insurance, and services not covered by an insurance company.
2. Payments may be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.
3. You may receive a separate bill for services provided by a FirstHealth Cardiology & Specialty Clinic provider at PMC.
4. Patients without insurance may be eligible to receive a discount for payment in full on the day services are provided. You will need to speak to a Patient Account Representative.
5. A No-Show Charge will apply should you fail to keep your scheduled appointment without giving us a 24-hour or greater advanced notice of your cancellation. Three (3) consecutive appointment cancellations and/or no-shows may result in dismissal from Pinehurst Medical Clinic. The No-Show fees are $75 for a new patient office visit, $25 for an established patient office visit, and $25-$250 for procedure/testing appointments.
6. Patients may be charged a fee for the completion of forms.
7. Patients who feel their level of income is not sufficient to enable them to pay the amount they owe may apply for financial assistance by completing an application. This application may be obtained from one of our financial representatives or by calling Financial Services at 910-295-9391. Please note in general, financial assistance is extended only to patients whose family income is at or below 150% of the federal poverty limits.
8. Balances due after your insurance has paid will be reflected on billing statements sent to the patient's, or responsible party's, address. The amount due on the statement is due in full upon receipt. If you are unable to pay the amount in full it is your responsibility to call Financial Services to discuss making other payment arrangements.
9. Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been filed with your insurance for over 60 days without a response, please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.
10. It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.
11. Services received as a result of an accident are to be paid promptly. We do not allow additional time for payment where the accident results in a lawsuit or insurance case.
12. If your health insurance plan requires a preauthorization or referral, it is your responsibility to ensure it is obtained before services are received.
13. New patient visits are coded per industry standards based on whether the patient is new to the specialty or subspecialty. Reference the following link for additional information: https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/
14. Failure to pay a balance due promptly may result in one or more of the following:
    a. Your account may be referred to a collection agency,
    b. Your past due status may be reported to the applicable credit bureaus,
    c. Your ability to receive services from Pinehurst Medical Clinic may be jeopardized.
15. Billing codes will reflect all services provided during an appointment, e.g. if a new or chronic health issue is addressed during an annual wellness visit, a copay fee, co-insurance or deductible will apply depending on the patient's insurance plan. Evaluation and management of new or chronic health issues is not considered a part of the annual wellness visit and is a separate billable service.

We encourage those who have questions regarding this policy document or any aspect of their bill to contact us at (910) 295-9391 or toll-free at (866) 327.3159.

Pinehurst Medical Clinic

Access Your Health Information Online

Where you need it, when you need it.

Powered By FollowMyHealth

An all-in-one personal health record & patient portal that lets you access your health information online & on the go!

- View test & lab results
- Receive email care reminders
- Send & receive secure online messages
- Request appointments
- Request Rx refills
- Set up proxy accounts for children & dependent adults

To get started with a new account, give receptionist your email. To log in to an existing account, scan below.

Questions?

Call (910) 235-3380 or email fmhsupport@pinehurstmedical.com