MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

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S. ALEXANDER WOODS, Jr., M.D.
S. JUNAID ZAIDI, M.D.

Dear Patient:

You are scheduled to see Dr. ______________________________

On ________________________ at ________________ a.m./p.m.

Our office is located in the, **I Bank Tower at 5050 Poplar Ave., Suite 800.**

Please complete the enclosed forms and bring with you to your appointment. If you need assistance in completing these forms, please arrive at our office 30 minutes before your scheduled appointment and our staff will be happy to assist you.

We ask that you bring with you the following items:

- Any recent chest x-rays or CT scans
- All medications that you are currently taking
- All insurance information

Please be prepared to pay for any outstanding deductibles or co-payments at the time of your visit. We ask that you NOT wear perfume or cologne as many of our patients are very sensitive to fragrances.

Also, please understand that we are a SPECIALITY MEDICAL PRACTICE and give all our patients quality medical care; therefore, you may experience a **LENGTHIER waiting time** than you are accustomed to. If you are unable to keep your appointment please call and we will be happy to reschedule it for you.

If you have any questions, please call us at (901) 276-2662 between the hours of 8:30 a.m. and 4:30 p.m.

We look forward to meeting your healthcare needs.

MEDICAL STAFF / PRESCRIPTION REFILLS
901-276-2663
901-276-8042 FAX

5050 POPLAR AVENUE, SUITE 800
MEMPHIS, TN 38157
MAIN PHONE: 901-276-2662
MAIN FAX: 901-274-1871

BILLING DEPARTMENT
901-276-9944
901-276-8631 FAX

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5050 POPLAR AVENUE, SUITE 800
MEMPHIS, TN 38157
(901) 276-2662
www.mspulmonary.com

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

I authorize medical treatment by my physician. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health insurance benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing. I have received a copy of the Mid-South Pulmonary Specialists, P.C. Notice of Privacy Practices for Health Related Information.

ARE YOU HISPANIC OR LATINO--YES/NO

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________________

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
MEDICATION VERIFICATION SHEET

PATIENT NAME ______________________________ CHART/MRN# ____________________

DATE OF VISIT ______________________________ ALLERGIES: ____________________

NAME OF PHARMACY ________________________ Pharmacy Phone #____________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.
(INCLUDING INHALERS AND VITAMINS)

MEDICATION NAME	DOSAGE/STRENGH/MG	FREQUENCY (times per day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

ARE YOU CURRENTLY TAKING ANY FORM OF BIRTH CONTROL? YES___ NO___

______________________________________ ____________________
SIGNATURE DATE

Rev. 10.3.19

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: ______________________________ SS#: ____________________________

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION CONTAINED IN MY MEDICAL RECORD TO THE FOLLOWING PERSONS:

____

____

I authorize the practice to disclose or provide protected health information directly to me at the email address, fax number, phone number, cell phone number, or alternative address that I have indicated below. I am also allowing Mid-South Pulmonary Specialists to leave a message on my answering machine or with the person answering the telephone regarding appointments, etc. I understand that it is my responsibility to notify the practice of my preferred method of communications or any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, and carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

☐ Cell phone: ☐ email address: ☐ mail: ☐ fax number: ☐ other phone: ☐ text message:

____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; or, check only those items of the record to be disclosed:

☐ Office notes
☐ Lab results, pathology reports
☐ X-rays
☐ Financial history report (previous 3 yrs. only)
☐ Nursing home, home health, hospice, and other physician records
☐ Only send the following: ____

PURPOSE OF DISCLOSURE (please state the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): ____

When requesting information to be disclosed, please specify the format in which you would like the PHI provide to you. We will accommodate your request, if possible. Please be advised that there may be costs involved in providing the PHI requested.

☐ Paper copy ☐ electronic copy via the following: ☐ CD ☐ flash drive ☐ other means: ______________________

By signing below, I agree with the following information:

Expirations or termination of authorization – This authorization will need to be renewed every twelve (12) months, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.
Please list desired expiration date: ______________________________
Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in-person or by mailing a written request to the practice, attn.: Compliance Office.
Non-Conditioning statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.
Re-disclosure Statement: I understand that the practice has no control regarding persons who may have access to the mailing address, email address, telephone, cell or fax number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

I understand that authorizing disclosure of this health information is voluntary. I do not need to sign this form to assure treatment. HOWEVER, IF THIS AUTHORIZATION IS NEEDED FOR PARTICIPATION IN A RESEARCH STUDY, MY ENROLLMENT IN THE STUDY MAY BE DENIED. Also, if this authorization is needed for the sole purpose of creating protected health information to disclose to a third party, my treatment may be denied.

I understand I am entitled to a copy of this form. I have seen and had an opportunity to read the notice of privacy practices for health related information.

______________________________ ______________________
Signature of patient or legal representative Date

____
Relationship to patient

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
PATIENT HEALTH HISTORY

Patient Name________________________ Date________________________
Address________________________ Date of Birth________________________
________________________ Social Security Number________________________

Explain why you are here to see the doctor today.________________________
____
____

Past Medical History

List the date of your most recent vaccinations
Flu________________
Pneumonia________________
Tetanus________________

List all **ALLERGIES**
____
____
____

Check if you have had the following conditions or procedures.

Asthma ___
Emphysema ___
COPD ___
Sarcoidosis ___
Pulmonary Fibrosis ___
Collapsed lung ___
Histoplasmosis ___
Tuberculosis ___
Chronic bronchitis ___
Bronchiectasis ___
Heart Disease ___
Hypertension ___
Blood clot-lung ___
Cancer ___
Rheumatoid Arthritis ___
Scleroderma ___
Lupus ___
Thyroid Disorder ___
Sleep Apnea ___
Sinusitis ___
Cataracts ___
Glaucoma ___
Seizure ___
Cystic Fibrosis ___
Sickle Cell Disease ___
Alpha-1 Antitrypsin Deficiency ___
Acid reflux (GERD) ___
HIV/AIDS ___
Stroke ___
Hepatitis ___
Diverticulitis ___
Ulcers ___
Diabetes ___

Appendectomy (appendix) ___
Hysterectomy (uterus) ___
Cholecystectomy (gall bladder) ___
Sinus surgery ___
Lung surgery ___
Heart Surgery ___
Aneurysm surgery ___
Bronchoscopy ___
Cataract surgery ___
Colon Surgery ___
Prostate Surgery ___
Brain Surgery ___
Tracheostomy ___
Lung biopsy ___

List any other surgeries, procedures or medical problems:
____
____
____
____
____
____
____
____
____
____
____
____

Family History

Check if any of your family members (mother, father, brother, sister, children) had any of the following medical conditions:

Diabetes	___	Emphysema	___
Stroke	___	Lung Cancer	___
Heart Disease	___	Asthma	___
Blood Clots	___	Pulmonary fibrosis	___
Hypertension	___	Cystic Fibrosis	___
Cancer	___	Tuberculosis	___

Social History

Have you ever smoked? Y N How much? ________ packs per day for _________ years

Do you drink alcoholic beverages? Y N How much? ___________________________

Have you ever been exposed to chemicals, dusts or fumes? Y N What types of work have you done in your lifetime? ____

System Review. Check if you have experienced any of the following in the past month.

General
- weight loss ___
- weight gain ___
- weakness ___
- fatigue ___
- fever ___
- rash ___
- hair loss ___

Head and Neck
- headache ___
- vision changes ___
- hearing loss ___
- earache ___
- nasal stuffiness ___
- sinusitis ___
- nosebleed ___
- sore throat ___
- hoarseness ___
- bleeding gums ___
- swollen glands ___
- goiter ___

Musculoskeletal
- joint pain ___
- arthritis ___
- gout ___
- muscle pain ___
- muscle cramps ___
- muscle weakness ___

Hematologic
- anemia ___
- easy bruising ___
- blood clots

Breasts
- lumps ___
- pain ___
- nipple discharge ___

Cardiac
- high blood pressure ___
- chest pain ___
- shortness of breath ___
- leg swelling ___
- palpitations ___
- passing out ___
- aneurysm ___

Gastrointestinal
- heartburn ___
- loss of appetite ___
- nausea ___
- vomiting ___
- vomiting blood ___
- bloody bowel movements ___
- diarrhea ___

Neurologic
- fainting ___
- seizure ___
- headache ___
- numbness ___
- weakness ___
- tremor ___
- memory loss ___

Endocrine
- thyroid problems ___
- goiter

Respiratory
- wheeze at rest ___
- wheeze with activity ___
- cough ___
- sputum production ___
- coughing up blood ___
- chest pain ___
- shortness of breath
  - at rest ___
  - lying down ___
  - at night ___
  - with activity ___

Genitourinary
- frequent urination ___
- painful urination ___
- bloody urine ___
- incontinence ___
- prostate problems ___
- heavy menstrual period ___
- vaginal discharge ___

Sleep Disorders
- snoring ___
- stop breathing during sleep ___
- daytime sleepiness ___
- never feel rested ___
- frequent naps ___
- fall asleep while driving ___
- early morning headache ___
- leg swelling ___

NAME: ______________________________ MRN: ______________

PLEASE PLACE A CHECK MARK BESIDE ANY SYMPTOM YOU HAVE HAD IN THE PAST TWO WEEKS

Do you have an Advanced Directive? ___YES ___NO

(Legal documents that allow you to plan and make your own end-of life wishes known in the event that you are unable to communicate.)

1. _____ Have you had chills?
2. _____ Have you had fever?
3. _____ Have you had night sweats?
4. _____ Have you been hoarse?
5. _____ Have you had a sinus infection?
6. _____ Do you snore at night?
7. _____ Have you had a sore throat?
8. _____ Have you had chest pain?
9. _____ Have you had swelling in your hands or feet?
10. _____ Have you felt your heart racing?
11. _____ Have you had indigestion?
12. _____ Do you take birth control? If yes, what type?_______________
13. _____ Have you had a rash?
14. _____ Have you been dizzy?
15. _____ Are you excessively sleepy during the day?
16. _____ Have you had a headache?
17. _____ Have you passed out?
18. _____ Have you had a cough?
19. _____ Have you coughed up blood?
20. _____ Do you wake up during the night short of breath?
21. _____ Are you short of breath at rest?
22. _____ Are you short of breath during activity/walking?
23. _____ Are you short of breath lying down?
24. _____ Have you heard yourself wheeze?
25. _____ Do you bruise easily?
26. _____ Do you smoke? _____ Yes _____ No. If yes, how much per day? _______________
27. _____ Are you a former smoker? ___Yes ___ No If, yes, how many YEARS did you smoke? ________
    How many PACKS per day did you smoke? _______________
28. _____ Do you chew tobacco? Y/N Smoke electronic cigarettes? Y/N
29. _____ Have you had any surgical procedures since your last visit? If so, what _______________
30. _____ When was your last flu shot? _____
31. _____ Have you ever had a pneumonia shot? If yes, when? ___________

SIGNATURE: ______________________________ Date: ______________

DOB: ____/___/____

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