NORTHWEST PULMONOLOGY

NEW PATIENT REGISTRATION

NORTHWEST SPECIALTY HOSPITAL

1) Full Legal Name			Previous Last Name
Last	First	M.I.	

2) Gender	Social Security Number	Date of Birth
❑ Female ❑ Male ❑ Unknown ❑ Other _____		
Martial Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed		

3) Mailing Address			
Street or PO Box	City	State	Zip Code

4) Contact Information (Please check your preferred contact number)			
❑ Cell phone	❑ Home phone	❑ Work Phone	❑ Email

5) Employer			
Name		Phone	
Street	City	State	Zip Code

6) Preferred Pharmacy			
Name		Phone	
Street	City	State	Zip Code

7) Emergency Contact		
Name	Relationship	Phone

8) Primary Care Provider		
Name	Address	Phone

9) Referring Provider		
Name	Address	Phone

NORTHWEST PULMONOLOGY

NEW PATIENT REGISTRATION

NORTHWEST SPECIALTY HOSPITAL

10) Guarantor			
Last	First		M.I.
Street or PO Box	City	State	Zip Code
SSN	Phone	Relationship to patient	

11) Insurance Information			
Primary Insurance Company Name	ID#	Group#	Phone
Subscriber-Employee Name	SSN	DOB	Relationship to patient
Secondary Insurance Company Name	ID#	Group#	Phone
Subscriber-Employee Name	SSN	DOB	Relationship to patient

12) Demographic Information

❑ Decline ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American
❑ Other _____

13) Ethnic Information

❑ Declined ❑ Not Hispanic or Latino ❑ Hispanic or Latino

14) Preferred Language

❑ English ❑ French ❑ Russian ❑ Arabic ❑ German ❑ Spanish ❑ Chinese ❑ Japanese
❑ Vietnamese ❑ Other _____

I hereby authorize any insurance benefits to be paid directly to Northwest Specialty Hospital. I understand that I am responsible for paying non-covered services. I hereby authorize the release of pertinent medical information to my insurance carriers and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I have verified that demographics information sheet to be true and correct.

_____
Signature (Patient or Guardian) Date

_____
Relationship to patient

MEDICAL HISTORY

1) ALLERGIES	
MEDICATIONS	
FOOD	
ENVIRONMENT	
HAVE YOU EVER HAD ALLERGY TESTING?	❑ YES ❑ NO
ARE YOU ALLERGIC TO LATEX?	❑ YES ❑ NO

2) MEDICATIONS

Please list all of the medications you are currently taking.

MEDICATION	DOSE	FREQUENCY

3) PAST MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

- ❑ High Blood Pressure
- ❑ Headaches/Migraines
- ❑ Seizures/Epilepsy
- ❑ Numbness of face, arms hands, or legs
- ❑ COPD
- ❑ Asthma (if yes medication used.)

  _____
- ❑ Chest pain or shortness of breath.
- ❑ Heart disease (murmur or valve prolapse)
- ❑ Thyroid problems
- ❑ Liver Disease
- ❑ Tuberculosis
- ❑ Weakness in the Extremities
- ❑ Blood clots
- ❑ Cancer (If yes, type)

  _____
- ❑ Depression/mental illness
- ❑ Stroke
- ❑ Anemia (low iron in your blood)
- ❑ Diabetes
- ❑ Major injuries/traumas
- ❑ Lung problems
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Sleep Apnea

4) PAST SURGERIES OR HOSPITALIZATIONS

TYPE:		DATE:	
TYPE:		DATE:	
TYPE:		DATE:	

5) FAMILY HISTORY

Does anyone in your family have a present or past history of the following:

- ❑ Bleeding disorders
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High blood pressure
- ❑ Thyroid disorders
- ❑ Strokes
- ❑ COPD
- ❑ Asthma

6) PERSONAL / SOCIAL HISTORY			
Which statement describes your current tobacco use? (Choose all that apply)			
❑ I have never smoked cigarettes. (a) If you have only tried smoking check this box ❑			
❑ I stopped smoking within the past year.			
❑ I dip, chew, or use smokeless tobacco.			
❑ I smoke e-cigarettes/vapor.			
❑ I smoke regularly now.			
How many years have you used tobacco?		How much? (packs)	
Do you consume alcohol?	❑ YES ❑ NO	How many times per week?	
How many times per month?		How many drinks per time?	
Do you use any illicit drugs?	❑ YES ❑ NO		
If yes, what drugs			
Do you feel safe in your current relationship	❑ YES ❑ NO		
Over the past (2) two weeks, how often have you been bothered by any of the following problems:			

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Have you ever been emotionally or physically abused?	❑ YES ❑ NO		
Do you have a support system (i.e., friends/family)?	❑ YES ❑ NO		
Date of last eye exam		Date of last dental exam	
Date of your last tetanus injection			

7) REVIEW OF SYSTEMS (LAST SIX MONTHS)	
CONSTITUTIONAL	❑ FATIGUE ❑ FEVER ❑WEIGHT LOSS_____LBS ❑ WEIGHT GAIN_____LBS
EYES	❑ BLURRED VISION ❑ DOUBLE VISION ❑ ITCHING ❑ BURNING ❑ EYE PAIN
EARS	❑ DIFFICULTY HEARING ❑ EAR PAIN ❑ VERTIGO ❑ TINNITUS ❑ EARS FEEL PRESSURED ❑ DISCHARGE FROM THE EARS
NOSE	❑ FREQUENT NOSEBLEEDS ❑ NASAL CONGESTION ❑ CHRONIC RUNNY NOSE ❑ NOSE/SINUSPRESSURE ❑ BLOCKAGE/OBSTRUCTION
MOUTH/THROAT	❑ SORE THROAT ❑ BLEEDING GUMS ❑ SNORING ❑ DRY MOUTH ❑ MOUTH ULCER ❑ POSTNASAL DRIP ❑ HOARSENESS
NEUROLOGIC	❑ FAINTING FREQUENT ❑ SEIZURES ❑ NUMBNESS ❑ WEAKNESS ❑ RESTLESS LEGS
CARDIOVASCULAR	❑ CHEST PAIN ❑ MURMUR ❑ IRREGUAR HEARTBEAT ❑ SWELLING ❑ LIGHTHEADED ON STANDING
RESPIRATORY	❑ WHEEZING ❑ SHORTNESS OF BREATH ❑ COUGHING BLOOD
GENITOURINARY	❑ DIFFICULTY URINATING ❑PAIN DURING URINATION
GASTROINTESTINAL	❑ VOMITING ❑ PAINFUL SWALLOWING ❑DIFFICULTY SWALLOWING
HEM/LYMPH	❑ SWOLLEN GLANDS ❑ EASY BRUISING ❑ EXCESSIVE BLEEDING

7) REVIEW OF SYSTEMS (LAST SIX MONTHS) contd...	
PSYCH	❑ DEPRESSION ❑ ANXIETY
MUSCULOSKELETAL	❑ MUSCLE ACHES ❑ JOINT PAIN
SKIN	❑ ITCHING ❑ RASH ❑ DRY SKIN ❑ GROWTHS/LESIONS
ENDOCRINE	❑ HAIR LOSS ❑ SENSITIVITY TO HEAT OR COLD
ALLERGY	❑ FREQUENT SNEEZING ❑ RUNNY NOSE
❑ OTHER	

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SIGNATURE (PATIENT OR GUARDIAN) _____ DATE (MM-DD-YYYY) _____ RELATIONSHIP TO PATIENT _____

ACKNOWLEDGEMENT OF RECEIPT OF LEGAL NOTIFICATIONS

NORTHWEST SPECIALTY HOSPITAL

I HAVE been offered/received a copy of legal notifications at Northwest Specialty Hospital which includes the following:

- Patient Rights & Responsibilities
- Privacy Notice
- EMTALA Notification
- Notice of Non-Discrimination & Accessibility Requirements
- Notice of Physician Staffing & Emergency Procedures
- Notice of Physician Ownership
- Financial Assistance
- Your Rights and Protection Against Surprise Billing

NAME (PRINT, FULL LEGAL)

Relationship

SIGNATURE

DATE

ADMINISTRATIVE USE ONLY

Witness

Date

RELEASE OF INFORMATION FROM OTHER HEALTHCARE PROVIDERS

NORTHWEST SPECIALTY HOSPITAL

PULMONOLOGY

I,_____,_____, hereby authorize the following providers:
(PATIENT NAME) (DATE OF BIRTH)

LIST ALL PROVIDERS FROM WHOM INFORMATION IS BEING SOUGHT:

PROVIDER	ADDRESS	PHONE	FAX
PROVIDER	ADDRESS	PHONE	FAX

TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION TO:

Northwest Pulmonology
1551 E Mullan Ave, STE 200C
Post Falls, ID 83854
Phone: (208) 618-2570 Fax: (208) 618-8779

INFORMATION TO BE RELEASED: **(CHECK ALL THAT ARE APPLICABLE)**

- ☐ Copies of EKGs taken within the past five years.
- ☐ Medical history, including specific progress notes regarding any problems that would impact my surgery or procedure's progress or outcome.
- ☐ A list of allergies.
- ☐ Results of relevant diagnostic or laboratory tests.
- ☐ Entire medical record.
- ☐ Other _____

EXCLUDE THE FOLLOWING INFORMATION FROM THE RECORDS RELEASED: **(PLEASE INITIAL)**

_____ Drug/Alcohol abuse/treatment and diagnosis _____Sexually transmitted disease

_____ Mental Illness or psychiatric diagnosis and treatment _____HIV/AIDS

This protected health information will be used by the Facility listed above for the purpose of treatment.
This authorization shall be in force and effect until_____**(date).**
I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the provider(s) listed above.
I understand that a revocation is not effective to the extent that the provider(s) listed above have relied on this form to use or disclose protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy requirements law. However, the Facility is covered by federal privacy requirements and will follow them.
I understand that the provider(s) listed above will not condition treatment, payment, enrollment in a health plan or program, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____
PRINTED OR TYPED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2002 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

I, _____ acknowledge that I have been offered/received a copy of the Privacy Notice.

In addition to our normal operational disclosures of privacy information, please identify to whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the party or parties listed below to request this information:

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

PRINTED PATIENT NAME _____ SIGNATURE PATIENT OR REPRESENTIVE _____ DATE _____

For Facility use only:

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

NAME _____ DATE _____

MEDICARE SECONDARY PAYER FORM (MSP)

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2003 | PHYSICIAN OWNED AND OPERATED BY PHYSICIANS

PART I: Information about Black Lung, Workers' Compensation, No-Fault Liability

1. Are you receiving benefits under the Black Lung Benefits Act? Yes ☐ No ☐
   If Yes: Date the benefits began: _____
2. Was this injury/illness due to a work related accident/condition? Yes ☐ No ☐
   If Yes: Name and Address of employer: _____
   Name and address of insurance carrier: _____
   Policy or claim number: _____ Date of workplace illness or injury: _____
3. Are you receiving treatment for an injury or illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? Yes ☐ No ☐
   If Yes: Name and Address of insurance carrier: _____
   Policy or claim number: Date of workplace illness or injury:
4. Are you receiving treatment for an injury or illness, which another party may be liable? Yes ☐ No ☐
   If Yes: Name and Address of insurance carrier: _____
   Policy or claim number: Date of illness or injury:

PART II: Information about Medicare Entitlement and Group Health Plans

1. Are you entitled to Medicare based on ☐ Age ☐ Disability ☐ ESRD (Skip to Part III)
2. Do you have a group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? Yes ☐ No ☐ *If No, stop here*
3. How many employees, including yourself or spouse, work for the employer from whom you have GHP coverage? *(Note: if you are aged and there are 20 or more employees, your GHP is primary. If you are disabled and your employer, spouse or family member employer, has 100 or more employees, your GHP is primary.)* ☐ 1-19 ☐ 20-99 ☐ 100+
4. The following employer GHP information is required to submit claims appropriately
   Name and address of employer through which you receive GHP coverage: _____
   Name and address of GHP: _____
   Policy number: _____ Group number: _____
   Date the GHP coverage began: _____
   Name of policyholder (if coverage through spouse/other family): _____
   Relationship to patient (if other than self):

PART III: Information about the Patient if ESRD Medicare Entitlement Applies

1. Do you have an employer group health plan (GHP) coverage through yourself, a spouse or family member if dually entitled based on Disability and ESRD? Yes ☐ No ☐ *If Yes, continue*
2. Have you received a kidney transplant? Yes ☐ No ☐
   If Yes: Date of transplant: _____
3. Have you received maintenance dialysis treatments? Yes ☐ No ☐
   If Yes: Date dialysis began: _____
4. Are you within the 30-month coordination period? Yes ☐ No ☐
5. Were you receiving GHP coverage prior to and on the date of Medicare entitlement due to ESRT (or simultaneous entitlement due to ESRD and Age or ESRD and Disability)? Yes ☐ No ☐
6. The following information is required to submit claims appropriately:
   Name and address of employer through which you receive GHP coverage: _____
   Name and address of GHP: _____
   Policy number: _____ Group number: _____
   Name of policyholder (if coverage through spouse/other family): _____
   Relationship to patient (if other than self):

PRINTED PATIENT NAME | SIGNATURE PATIENT OR REPRESENTIVE | DATE

PATIENTS GUARDIAN OR REPRESENTATIVE | RELATIONSHIP | WITNESS