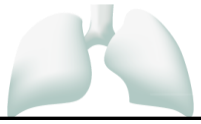


MONMOUTH OCEAN PULMONARY MEDICINE

NAME			DATE OF BIRTH	
ADDRESS		CITY	STATE	ZIPCODE
PHONE #'S	HOME	MOBILE		WORK
SOCIAL SECURITY #		DO YOU HAVE A LIVING WILL [ ] YES [ ] NO		
PATIENT EMPLOYER		OCCUPATION		
EMPLOYER ADDRESS		CITY	STATE	ZIPCODE

POLICY HOLDER INFORMATION AND BIRTHDATE MUST BE FILLED OUT COMPLETELY

MUST BE FILLED OUT COMPLETELY

PRIMARY INSURANCE		POLICY #	GROUP #
POLICY HOLDER IS [ ]SELF [ ]SPOUSE [ ]PARENT		POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SSN
POLICY HOLDER EMPLOYER			EMPLOYER PHONE #
EMPLOYER ADDRESS	CITY		STATE/ZIP CODE
SECONDARY INSURANCE		POLICY #	GROUP #
POLICY HOLDER IS [ ]SELF [ ]SPOUSE [ ]PARENT		POLICY HOLDER DATE OF BIRTH	POLICY HOLDER SSN
POLICY HOLDER EMPLOYER			EMPLOYER PHONE #
EMPLOYER ADDRESS	CITY		STATE/ZIP CODE

FAMILY PHYSICIAN		PHONE #
REFERRED BY		PHONE #
LOCAL PHARMACY	CITY	PHONE #
MAIL AWAY PHARMACY	CITY	PHONE #

POWER OF ATTORNEY OR SIGNING ON PATIENTS BEHALF

PERSONAL REPRESENTATIVE	RELATIONSHIP
PATIENT NAME	PATIENT SIGNATURE

THE ABOVE AUTHORIZATION WILL APPLY TO THE TIME PERIOD AS FOLLOWS:

FROM TODAY:_____/_____/_____ UNTIL
[ ] I CANCEL THIS AUTHORIZATION -OR
[ ] UNTIL THIS DATE _____/_____/_____

MONMOUTH OCEAN PULMONARY MEDICINE

PATIENT NAME	PATIENT DATE OF BIRTH

REASON FOR VISIT

WHAT IS THE REASON FOR TODAYS VISIT?
HOW SEVERE IS THE PROBLEM?
DOES THE PROBLEM OCCUR AT A SPECIFIC TIME?
WHAT OTHER PROBLEMS HAVE YOU BEEN HAVING?
HOW LONG HAVE YOU HAD THIS PROBLEM?
WHERE WERE YOU AT THE ONSET OF THIS PROBLEM?
COLOR OF SPUTUM (IF ANY)

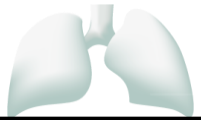
PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

PATIENT MEDICAL HISTORY							
ASTHMA			BACK PAIN			STROKE	
SLEEP APNEA			ABNORMAL XRAY			HEART DISEASE	
COPD			ABNORMAL CT			ARTHRITIS	
COUGH			ABNORMAL PFT			SEIZURES	
SHORT OF BREATH			DIABETES			BLEEDING TENDENCY	
WHEEZING			HYPERTENSION			ACUTE INFECTIONS	
CHEST PAIN			CANCER			HEREDITARY DEFECTS	

PREVIOUS HOSPITALIZATIONS, SURGERIES OR ILLNESSES	
	DATES
	DATES
	DATES
	DATES
	DATES

ALLERGIES (INCLUDING MEDICATION ALLERGIES)

CURRENT MEDICATIONS AND DOSAGE



MONMOUTH OCEAN PULMONARY MEDICINE

PATIENT NAME	PATIENT DATE OF BIRTH

PATIENT DEMOGRAPHIC
(MUST SELECT AT LEAST ONE RACE AND ONE ETHNICITY)

RACE	ETHNICITY
[ ] AMERICAN INDIAN OR ALASKAN NATIVE	[ ] HISPANIC OR LATINO
[ ] ASIAN	[ ] NOT HISPANIC OR LATINO
[ ] BLACK OR AFRICAN AMERICAN	[ ] REFUSED TO REPORT/UNREPORTED
[ ] NATIVE HAWAIIAN	[ ] UNDEFINED
[ ] OTHER PACIFIC ISLANDER	
[ ] WHITE	
[ ] MORE THAN ONE RACE	
[ ] UNDEFINED	
[ ] REFUSED TO REPORT/UNREPORTED	

LANGUAGE(S) SPOKEN_____

PATIENT SOCIAL HISTORY

MARITAL STATUS	[ ] SINGLE	[ ] MARRIED	[ ] SEPARATED	[ ] DIVORCED	[ ] WIDOW
USE OF ALCOHOL	[ ] NEVER	[ ] RARELY	[ ] MODERATE	[ ] DAILY	
USE OF TOBACCO	[ ] NEVER	[ ] PREVIOUSLY, BUT QUIT (YEAR)_____	HOW LONG_____	HOW MUCH _____	
	[ ] CURRENTLY	DAILY AMOUNT _____			
EXPOSURE TO SECOND HAND SMOKE: [ ]YES [ ] NO	HOW OFTEN_____	WHEN_____			
USE OF DRUGS	[ ] NEVER	[ ] YES, TYPE/FREQUENCY			
EXCESSIVE EXPOSURE AT HOME OR WORK TO					
[ ] FUMES	[ ] DUST	[ ] SOLVENTS	[ ] AIRBORNE PARTICLES	[ ] NOISE	

FAMILY MEDICAL HISTORY

	AGE	DISEASES	CAUSE OF DEATH
FATHER			
MOTHER			
BROTHER			
SISTER			

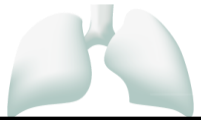
IMMUNIZATIONS

FLU	[ ]YES [ ]NO	DATE/YEAR	
PNUEMONIA	[ ]YES [ ]NO	DATE/YEAR	
TETANUS	[ ]YES [ ]NO	DATE/YEAR	

HAVE YOU EVER HAD A POSITIVE REACTION TO A TUBERCULOSIS SKIN TEST [ ] YES [ ] NO	
WHEN	TYPE OF TREATMENT

DO YOU HAVE PROBLEMS WITH THE FOLLOWING:

SLEEPING	[ ] YES	[ ] NO	FATIGUE	[ ] YES	[ ] NO
SNORING	[ ] YES	[ ] NO	FALLING ASLEEP WHILE DRIVING	[ ] YES	[ ] NO
DAYTIME SLEEPINESS	[ ] YES	[ ] NO	RESTLESS SLEEP	[ ] YES	[ ] NO



MONMOUTH OCEAN
PULMONARY MEDICINE

PATIENT NAME	PATIENT DATE OF BIRTH

HIPAA FORM

IN COMPLIANCE WITH HIPAA REGULATIONS AND TO ENSURE PATIENT PRIVACY, PLEASE COMPLETE THE FOLLOWING

**ORDINARLY, WE WOULD NOT DISCUSS YOUR MEDICAL SITUATION, TEST RESULTS OR BILLING INFORMATION WITH ANYONE BUT YOU OVER THE PHONE. HOWEVER, WITH YOUR CONSENT WE WILL SPEAK TO ANYONE YOU AUTHORIZE.*
**PLEASE UNDERSTAND YOU ARE WAIVING YOUR RIGHT OF CONFIDENTIALITY IF YOU GIVE YOUR PERMISSION*

MY PHYSICIAN AND THE OFFICE STAFF MAY DISCUSS MY CONDITION, TREATMENT AND RESULTS WITH THE FOLLOWING PEOPLE:

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

CONSENT TO LEAVE MESSAGES ON A TELEPHONE ANSWERING MACHINE

**IN ORDER TO PROTECT YOUR CONFIDENTIALITY, WE ORDINARLY WOULD NOT LEAVE RESULTS ON YOUR ANSWERING MACHINE, HOWEVER WITH YOUR PERMISSION, WE CAN DO THIS.*
PLEASE UNDERSTAND THAT YOU ARE WAIVING YOUR RIGHT OF CONFIDENTIALITY BY GIVING YOUR CONSENT.

***PLEASE CHOOSE ONE**

I GIVE CONSENT TO MOPM TO LEAVE DETAILED MESSAGES* AT THIS PHONE #_____
****DETAILED MESSAGES INCLUDES: RESULTS, INFORMATION ABOUT TREATMENT AND APPT INFORMATION***

OR

I GIVE CONSENT TO MOPM LEAVING A MESSAGE TO CONFIRM APPOINTMENT OR ASKING YOU TO RETURN OUR PHONE CALL AT THIS PHONE #_____

PLEASE PROVIDE YOUR EMAIL ADDRESS IF YOU WISH TO HAVE ACCESS TO OUR PATIENT PORTAL
**WITH ACCESS TO OUR PATIENT PORTAL, YOU WOULD BE ABLE TO VIEW APPOINTMENTS, CANCEL APPOINTMENTS & VIEW AND PRINT YOUR MEDICAL RECORD.*

I WISH TO PROVIDE MY EMAIL ADDRESS FOR THE PURPOSE OF THE PATIENT PORTAL [ ] YES [ ] NO

EMAIL ADDRESS (PLEASE PRINT)

EMERGENCY CONTACT

***PLEASE PROVIDE SOMEONE WE SHOULD CONTACT IN THE EVENT OF AN EMERGENCY**

NAME_____ RELATIONSHIP_____ PHONE #_____

MONMOUTH OCEAN
PULMONARY MEDICINE

We are committed to providing you with the best possible care.

**In order to achieve this goal, we need your assistance and understanding of our payment policy.
The following is a statement of our financial policy, which we request you read and sign prior to treatment.**

If we are participating providers with your insurance company, we will bill them for any eligible charges you may incur. You will be responsible for your co-pay, non-covered services and deductible amounts in accordance with your policy provisions.

If you belong to an HMO, you must have the required referral form from your PCP at the time of your visit. If a referral form is not available at the time of your visit, you will need to reschedule your appointment.

If we are not participating providers with your insurance carrier, full payment is required at the time of your visit. Most insurance companies have their own fee schedule and it rarely is the same as the physicians. Your health insurance coverage is a contract between you and your insurance carrier. Please direct and questions to them.

Medicare: All of our Doctors participate with Medicare. Your claim will be filed for you. At the time of service, you will be requested to pay your portion of Medicare's fee schedule. If you have a secondary insurance that we participate with, you are responsible for any co-pays, coinsurance, and deductibles. Please note that each year Medicare has a deductible and the amount may be requested by our office up front prior to the visit.

When paying with a check, note that all checks returned for insufficient funds, will incur a fee of $35.00

Please be advised that this practice reserves the right to assess a charge of $75.00 for a missed appointment- if 24 hours is not given, or if the patient arrives too late to be seen at the scheduled time. Please understand this is a courtesy to your fellow patients and will allow us the opportunity to see patients in a more productive and timely manner.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR MY TREATMENT.

SIGNATURE_____ **DATE**_____

PRINT NAME_____ **DATE OF BIRTH**_____

ACKNOWLEDGEMENT & CONSENT OF NOTIFICATION OF PRIVACY PRACTICES-MOPM

By signing below, I acknowledge that I have been advised of how health information about me may be used as disclosed by this practice. By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice and its staff.

SIGNATURE_____ **DATE**_____