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Welcome to Midwest Chest Consultants, P.C.

We are thrilled to welcome you to our office! To get started with your healthcare journey with us, please take a moment to review the attached new patient forms. Please note failure to have the forms completed in full prior to your appointment time will likely result in the appointment needing to be rescheduled to our first available spot. Please arrive 15 minutes early for registration and bring this completed paperwork with you to your appointment.

It is important to bring the following to every visit you have with our office:

- Photo ID
- Insurance Cards: Primary and Secondary (if applicable)
- Co-Payment: Due at time of service. We accept cash, check, money order, and debit/credit card (Visa, Mastercard, or Discover). There is an additional $25.00 fee for returned checks
- A list of your current medications and/or supplements

If you have any questions about the forms or need assistance completing them, please do not hesitate to contact our office at 636-946-1650 option 5 for the appointment line.

We look forward to meeting you and providing you with excellent care!

MIDWEST CHEST CONSULTANTS, P.C.
REGISTRATION FORM

Patient Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____/_____/_____ Soc Sec #: _____ Sex: M F

Race: (Optional) _____ Primary Language: _____

Home #: _____ Cell #: _____ Work#: _____

Address: _____ (City) _____ (State) _____ (Zip) _____

E-Mail: _____

Patient's Employer: _____

Which would you like to be contacted on first: (Circle) Home Cell Work

How would you like your confirmations for appointments: (Circle) Text Call E-mail

Marital Status: (Circle) Married Single Divorced Widowed Other: _____

Spouse's Name: _____ Spouse's Date of Birth: _____/_____/_____

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: (Last) _____ (First) _____

Phone #: _____ City: _____

PATIENT INFORMATION RELEASE (HIPAA REQUIRED)

Home:
□ Leave message with detailed information
□ Leave message with call back number only

Cell:
□ Leave message with detailed information
□ Leave message with call back number only

Please select ONE of the following:

□ OK to discuss medical information with: _____

(List names and relationships if left blank we will not be able to discuss anything with anyone. Including when your appointment is)

OR

□ Do **NOT** give out any information, even to family, unless specifically authorized. Medical information will be released to your primary physician and insurance company.

***** RESEARCH:** Would you like to hear about how our research program may benefit you? Yes No ***

INSURANCE RELEASE INFORMATION

I hereby authorize the office of Midwest Chest Consultants, PC to release my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to my physician. I understand I am financially responsible for any balance not covered by my insurance carrier. In the case of a returned check there will be and additional $25.00 charge. I acknowledge the above information to be accurate.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

Patient Name: _____ Date: _____/_____/_____

Patient Date of Birth: _____/_____/_____

Please describe your current complaint or reason you are seeing the doctor:

_____

_____

_____

When did problem(s) begin? _____ Are complaints work related: Yes _____ No _____

ALLERGIES AND/OR MEDICINE REACTIONS

Do you have allergies or reactions to any medications/substance? Yes _____ No _____

If yes, type of reaction: (ex. Rash, swelling, etc…)

Rx/Substance: _____ Reaction: _____

Rx/Substance: _____ Reaction: _____

Rx/Substance: _____ Reaction: _____

Rx/Substance: _____ Reaction: _____

SMOKING/ALCOHOL HISTORY

Have you / Do you Smoke?

Never _____ Currently_____ Past/Quit_____ Date Quit _____/_____/_____

Packs per day_____ Number of years_____

Other:

Pipe:_____ Cigar_____ Snuff____ Chew_____ Marijuana_____ Second Hand Smoke_____

Are you interested in quitting? Yes_____ No_____

Alcohol Consumption: None _____ Daily_____ Weekly_____ Monthly_____ Occasionally_____

What is your current activity level: Active _____ Sedentary_____ House-Bound _____

Have you traveled outside of the U.S. in the past five years? Yes _____ No _____

(If yes, where)_____

Current Occupation: _____

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

Date of last immunization: Influenza (Flu): _____
Pneumonia: _____ Type (Circle): Prevnar Pneumovax
COVID-19: _____ Type (Circle): J&J Moderna Pfizer

<u>HOSPITALIZATION / SURGERIES</u> (NOT LISTED ELSEWHERE) – TYPE AND DATE

_____ _____

_____ _____

_____ _____

_____ _____

If you have ever had a listed condition in the past, please check the *Past* column.
If you are presently troubled by a listed condition, please check the *Present* column.
If you have not experienced a problem, please check the *Never* column.

	Past	Present	Never	
Cough	☐	☐	☐	Productive: Yes ___ No ___ Color _____ Blood in Sputum: Yes ___ No___
Shortness of breath	☐	☐	☐	When: Activity ___ At Rest ___ Wakes Up at Night ___
Wheezing	☐	☐	☐	With Activity ___ Worse at Night ___
Lung Disease	☐	☐	☐	Emphysema ___ Asthma ___ Chronic Bronchitis ___ COPD_____
Heart Disease	☐	☐	☐	Heart Attack ___ CHF ___ Palpitations ___ Irregular Rhythm ___
Sinus/Nasal Problems	☐	☐	☐	Drainage ___ Color _____ Congestion ___
High Blood Pressure	☐	☐	☐	
Stroke	☐	☐	☐	
Pain	☐	☐	☐	Location _____
Cancer	☐	☐	☐	Location _____ When _____
Diabetes	☐	☐	☐	Insulin ___ Oral Medicines ___ Diet Controlled ___
Arthritis	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Congenital Disease	☐	☐	☐	
Immune Disease	☐	☐	☐	
Seizures	☐	☐	☐	
Headaches	☐	☐	☐	When: Any Time of Day ___ Morning ___ Evening ___
Weight Gain	☐	☐	☐	
Weight/loss	☐	☐	☐	
Depression	☐	☐	☐	
Anxiety	☐	☐	☐	
Sleep Problem	☐	☐	☐	Snoring ___ Gasping for Breath ___ Insomnia ___
Restless Legs	☐	☐	☐	During the Day ___ Worse at Night: Yes ___ No ___
Blood Clots	☐	☐	☐	Location _____ When _____
Dizziness	☐	☐	☐	
Abnormal Chest X-Ray	☐	☐	☐	Location _____ When _____
Other	☐	☐	☐	_____

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

FAMILY HX Parents	Father Alive Y N	Health Conditions/Cause of Death: _____	Mother Alive Y N	Health Conditions/Cause of Death: _____
Grandparents	Paternal Alive Grandfather Y N Grandmother Y N	Health Conditions/Cause of Death: _____ _____	Maternal Alive Grandfather Y N Grandmother Y N	Health Conditions/Cause of Death: _____ _____
Brothers	# Alive	Health Conditions:	# Deceased	Health Conditions/Cause of Death:
Sisters	# Alive	Health Conditions:	# Deceased	Health Conditions/Cause of Death:
Children Sons: Daughters:	# Alive	Ages & Health Conditions:	# Deceased	Ages & Health Conds./Causes of Death:

PHARMACY

Name and Location: _____ Phone #: ( ) _____

LIST OF CURRENT MEDICATIONS (may attach a copy or use back-side of page)

NAME OF MEDICATION	STRENGTH	TIMES PER DAY	REASON/USED TO TREAT

OTHER CONCERNS/INFORMATION

_____

_____

_____

_____