GENESEE LUNG ASSOCIATES

BOARD-CERTIFIED PULMONARY, CRITICAL CARE & SLEEP MEDICINE

DR M. GHIATH BAYASI | DR MUHAMMAD M. ABOUDAN | DR MOHAMMAD AL-ALI
DR OMAR KHORFAN | DR DALIA ZAKRI | DR ABI WAQAS

8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

Welcome to Genesee Lung Associates

New Patient Registration Packet (Fillable Form)

APPOINTMENT DATE

APPOINTMENT TIME

PROVIDER

LOCATION

Thank you for choosing Genesee Lung Associates for your pulmonary, critical care, or sleep medicine needs. To help your visit go smoothly, please complete this form electronically and bring a printed or digital copy with you, or submit it through our patient portal if available.

Please Bring the Following to Your Appointment

- Photo ID and all insurance card(s)
- A valid referral from your primary care physician (required for HMO plans)
- A complete list of your current medications and dosages
- Any prior chest X-ray, CT scan, or sleep study films/disc (if from an outside facility within the past 2 years)
- This completed packet

Appointment & Cancellation Policy

If you are unable to keep your appointment, we require at least 24 hours' notice, or a no-show fee may apply (see Financial Policy on the final page). Patients arriving more than 15 minutes late may be asked to reschedule at the discretion of the physician.

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

PATIENT INFORMATION FORM

Patient Demographics

PATIENT FULL NAME | DATE OF BIRTH | SEX

HOME ADDRESS

CITY | STATE | ZIP

HOME / CELL PHONE | WORK PHONE | EMAIL ADDRESS

MARITAL STATUS | SOCIAL SECURITY NUMBER

Care Team & Pharmacy

PRIMARY CARE PHYSICIAN | REFERRING PHYSICIAN (IF DIFFERENT)

CARDIOLOGIST (IF APPLICABLE) | OTHER SPECIALISTS

PRIMARY PHARMACY NAME | PHARMACY LOCATION / PHONE

Employment & Emergency Contact

EMPLOYER | EMPLOYER PHONE

EMERGENCY CONTACT NAME | RELATIONSHIP | PHONE

Reason for Today's Visit

REASON FOR VISIT / CHIEF CONCERN

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

INSURANCE INFORMATION

Primary Insurance

INSURANCE COMPANY

PHONE NUMBER

MEMBER / ID NUMBER

GROUP NUMBER

SUBSCRIBER NAME (IF DIFFERENT)

SUBSCRIBER DATE OF BIRTH

SUBSCRIBER'S RELATIONSHIP TO PATIENT

SUBSCRIBER EMPLOYER

Secondary Insurance (if applicable)

INSURANCE COMPANY

PHONE NUMBER

MEMBER / ID NUMBER

GROUP NUMBER

Managed Care / HMO Patients

If your insurance plan is a Health Maintenance Organization (HMO), a valid referral from your primary care physician must be on file with our office prior to your visit. Without a valid referral, we may be unable to see you.

Patient Authorization for Billing

I authorize my (or my child's) insurance benefits to be paid directly to Genesee Lung Associates and understand I am financially responsible for all charges. I consent to the release of my medical record as needed to verify, collect, or settle my account with any third-party payor or health benefit plan.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

DATE

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

MEDICAL & SURGICAL HISTORY

PATIENT NAME **DATE OF BIRTH**

Personal Medical History — Check all that apply

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Sleep Apnea
- ☐ Pneumonia
- ☐ Anemia
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Thyroid Disorder
- ☐ Rheumatoid Arthritis
- ☐ Hay Fever / Allergic Rhinitis
- ☐ Other Cancer
- ☐ COPD / Emphysema
- ☐ Pulmonary Fibrosis / ILD
- ☐ Lung Cancer
- ☐ TB or TB Exposure
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Bleeding Tendency
- ☐ Acid Reflux (GERD)
- ☐ Autoimmune Disease
- ☐ Diabetes

IF DIABETES OR CANCER, PLEASE SPECIFY TYPE

Surgical History — Check all that apply

- ☐ Lung Surgery
- ☐ Tracheostomy
- ☐ Heart Surgery
- ☐ Gallbladder Removal
- ☐ Tonsillectomy
- ☐ Breast Surgery
- ☐ Hysterectomy
- ☐ Appendectomy
- ☐ Bronchoscopy
- ☐ Nasal Polyp Removal
- ☐ Back Surgery
- ☐ Hernia Repair
- ☐ Thyroidectomy
- ☐ Prostate Surgery
- ☐ Varicose Vein Surgery
- ☐ Other

Current Respiratory Support

Are you currently using home oxygen? ☐ Yes ☐ No

FLOW RATE (L/MIN) **HOURS OF USE PER DAY**

Do you currently use a CPAP or BiPAP machine? ☐ Yes ☐ No

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

FAMILY HISTORY

PATIENT NAME **DATE OF BIRTH**

Please check all conditions that apply to your biological family members. This history focuses on cardiopulmonary conditions relevant to your evaluation.

Condition	Father	Mother	Sibling	Other
Asthma	☐	☐	☐	☐
COPD / Emphysema	☐	☐	☐	☐
Pulmonary Fibrosis / ILD	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐
Alpha-1 Antitrypsin Deficiency	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Heart Attack or Stroke	☐	☐	☐	☐
Blood Clots (DVT / PE)	☐	☐	☐	☐
Sudden Cardiac Death	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Overweight / Obesity	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

SOCIAL & OCCUPATIONAL HISTORY

PATIENT NAME | **DATE OF BIRTH**

Tobacco Assessment

- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Current Everyday Smoker
- ☐ Current Someday Smoker
- ☐ Current or Former Vape / E-Cigarette Use

PACKS PER DAY | **NUMBER OF YEARS** | **YEAR QUIT (IF FORMER)**

Alcohol & Caffeine Use

- ☐ Non-Drinker
- ☐ Occasional Alcohol Use
- ☐ Social Alcohol Use
- ☐ Moderate Alcohol Use
- ☐ Heavy Alcohol Use
- ☐ Coffee
- ☐ Tea
- ☐ Soda / Energy Drinks

Current or past recreational / illicit drug use? ☐ Yes ☐ No

TYPE / DETAILS

Occupational & Environmental Exposure History

Pulmonary conditions can be strongly influenced by workplace and environmental exposures. Please check all that apply.

CURRENT OR MOST RECENT OCCUPATION

- ☐ Asbestos
- ☐ Coal Dust
- ☐ Mold or Water-Damaged Buildings
- ☐ Farming or Animal Exposure
- ☐ Silica / Sand / Rock Dust
- ☐ Birds, Feathers, or Poultry
- ☐ Chemical Fumes or Gases
- ☐ Second-Hand Smoke Exposure

Household & Social Situation

LIVING SITUATION (ALONE / WITH FAMILY, PETS, ETC.) | **WORK STATUS**

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

PULMONARY SYMPTOM QUESTIONNAIRE

PATIENT NAME **DATE OF BIRTH**

Do you have a cough? ☐ Yes ☐ No

☐ Dry Cough ☐ Productive Cough
☐ Acute (< 3 weeks) ☐ Chronic (> 8 weeks)

SPUTUM COLOR

Have you coughed up blood (hemoptysis)? ☐ Yes ☐ No

Do you experience wheezing? ☐ Yes ☐ No

Do you have chest pain or chest tightness? ☐ Yes ☐ No

Do you wake up short of breath at night (PND)? ☐ Yes ☐ No

Do you need extra pillows to breathe lying flat (orthopnea)? ☐ Yes ☐ No

IF YES, HOW MANY EXTRA PILLOWS?

Do you have swelling in your legs or ankles? ☐ Yes ☐ No

Shortness of Breath — mMRC Dyspnea Scale

Please check the grade that best describes your breathlessness.

☐ Grade 0 — Only breathless with strenuous exercise
☐ Grade 1 — Breathless hurrying on level ground or up a slight hill
☐ Grade 2 — Walks slower than peers or stops to catch breath
☐ Grade 3 — Stops for breath after ~100 yards
☐ Grade 4 — Too breathless to leave the house / to dress

Prior Testing & Devices

Have you had pulmonary function tests (PFTs) before? ☐ Yes ☐ No

Have you had a chest CT scan before? ☐ Yes ☐ No

Have you had a bronchoscopy before? ☐ Yes ☐ No

Do you currently use a nebulizer and/or inhaler(s)? ☐ Yes ☐ No

LIST CURRENT INHALERS / NEBULIZER MEDICATIONS

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

SLEEP MEDICINE QUESTIONNAIRE

PATIENT NAME **DATE OF BIRTH**

Sleep Symptom Screening — Check all that apply

- ☐ Loud Snoring
- ☐ Daytime Sleepiness or Fatigue
- ☐ Dry Mouth or Sore Throat on Waking
- ☐ Insomnia (Trouble Falling/Staying Asleep)
- ☐ Witnessed Apneas / Gasping / Choking
- ☐ Morning Headaches
- ☐ Frequent Nighttime Urination
- ☐ Restless Legs / Leg Jerking During Sleep

Do you currently use a CPAP or BiPAP machine? ☐ Yes ☐ No

PRESSURE SETTING **MASK TYPE** **AVG. HOURS USED / NIGHT**

Epworth Sleepiness Scale

Rate the likelihood that you would doze off or fall asleep in each situation below (not just feeling tired). 0 = Would never doze 1 = Slight chance 2 = Moderate chance 3 = High chance.

Situation	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place (theater/meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, stopped for a few minutes in traffic	☐	☐	☐	☐

TOTAL SCORE

A total score greater than 10 suggests excessive daytime sleepiness and warrants further evaluation.

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

MEDICATIONS & ALLERGIES

PATIENT NAME **DATE OF BIRTH**

Drug Allergies

Do you have any drug allergies? ☐ Yes ☐ No

If yes, please list the medication and your reaction below:

Medication	Reaction

Current Medications

Please list all medications you currently take, including over-the-counter drugs, vitamins, and supplements.

Medication Name	Strength	Frequency	Prescribing Doctor

GENESEE LUNG ASSOCIATES

Board-Certified Pulmonary, Critical Care & Sleep Medicine
8220 S. Saginaw St, Ste 800, Grand Blanc, MI 48439
Office: 810-695-5864 | Fax: 810-695-2412

CONSENTS, PRIVACY & FINANCIAL POLICY

HIPAA Notice of Privacy Practices

In accordance with HIPAA (1996), Genesee Lung Associates protects the privacy of your health information and will not disclose it beyond treatment, payment, and healthcare operations without your consent. You have the right to receive a copy of our full Notice of Privacy Practices (§164.520). When we refer you to another provider, only the minimum information necessary is shared.

I do NOT authorize release of my information except as listed below ☐ Yes ☐ No

I authorize discussion of my care with the individual(s) listed below ☐ Yes ☐ No

NAME	RELATIONSHIP	PHONE

Appointment, Cancellation & Referral Policy

We reserve the right to charge a fee for any appointment not canceled with at least 24 hours' notice, for a missed appointment, or for an HMO visit without a valid referral on file: Established patients — $25 fee. New patients — $50 fee. Patients arriving more than 15 minutes late may be asked to reschedule, and the same fee may apply.

Payments

Co-payments are due at the time of your visit. We accept Visa, Mastercard, personal checks, money orders, and cash. A $25 fee applies to returned checks, and a $5 administration fee will be added to your statement if your copay is not paid at the time of your visit.

Consent for Treatment & Financial Responsibility

I voluntarily consent to examination and treatment by the physicians and staff of Genesee Lung Associates, including any diagnostic procedures or testing recommended as part of my evaluation. I agree to promptly pay for services rendered and understand that if it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in collection, including missed appointments without 24 hours' notice.

I acknowledge receipt of the Notice of Privacy Practices and agree to the policies described above.

PRINTED NAME OF PATIENT	DATE OF BIRTH

SIGNATURE OF PATIENT OR PARENT/GUARDIAN	DATE