PLEASE COMPLETE THE ENCLOSED PAPERWORK PRIOR TO YOUR FIRST VISIT

APPOINTMENT INFORMATION:

PHYSICIAN: ____

DAY/DATE: ____

ARRIVAL TIME: _____________________________________

APPOINTMENT TIME: _________________________________

LOCATION:

______ 631 Professional Drive
Suite 350
Lawrenceville, GA 30046
(Located in front of Gwinnett Medical Center ER off of Duluth Hwy, Lawrenceville)

______ 3855 Pleasant Hill Rd
Suite 180
Duluth, GA 30096
(Located in Hudgens Professional Building at intersection of Pleasant Hill and McClure Bridge Rd)

Please bring your picture ID and all insurance cards with you to your appointment.

Self-pay patients: We require a $125.00 deposit at time of service.

If you need to cancel or change your appointment, please call 24 hours in advance to avoid a $50.00 fee. 770-995-0630 ext: 133

Just a friendly reminder:

Please be considerate of others in our office by not wearing perfumes or scented lotions on the day of your visit.

We also request if you are a smoker, please refrain from smoking at least 3 hours prior to your visit.

Thank you,

The Doctors and Staff of Gwinnett Pulmonary Group

Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C

Board Certified

Pulmonary Medicine
Critical Care
Sleep Medicine

Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.
Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Susan Mucha, M.D.

NAME:____ Date of Birth:______________________

(First) (Middle) (Last)

ADDRESS____

(City) (State) (Zip)

HOME PHONE_____________________________WORK PHONE_______________________________________

SS#___________________________________CELL PHONE ____

E-MAIL ADDRESS ____________________________ Who referred you to our office?____________________________

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU (in case of emergency):__________________________________

ADDRESS____

(City) (State) (Zip)

PHONE_________________________________ RELATIONSHIP TO PATIENT______________________________

Person Responsible For This Account

(if different from above)

NAME____ DATE OF BIRTH______________________

(First) (Middle) (Last)

ADDRESS____

(City) (State) (Zip)

HOME PHONE_________________________________WORK PHONE__________________________________

SS#_______________________________ RELATIONSHIP TO THE PATIENT___________________________________

EMPLOYER_____________________________ EMPLOYER PHONE____________________________________

EMPLOYER ADDRESS____

(City) (State) (Zip)

PLEASE FILL IN INSURANCE INFORMATION FOR PRIMARY INSURANCE COMPANY

PRIMARY INSURANCE COMPANY NAME	NAME OF INSURED	RELATIONSHIP TO PATIENT

PLEASE FILL IN INSURANCE INFORMATION FOR SECONDARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY NAME	NAME OF INSURED	RELATIONSHIP TO PATIENT

SHOULD THIS BE FILED UNDER WORKER'S COMPENSATION? ____

IF YES, PLEASE LIST THE DATE OF THE ACCIDENT ____

Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C

Board Certified

Pulmonary Medicine
Critical Care
Sleep Medicine

Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.
Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Susan Mucha, M.D.

NAME: Date of Birth:

Mail Order Pharmacy Name: ____

Local Pharmacy Name:____

City Where Pharmacy Is Located: ____________________ Pharmacy #____________________

Medication Allergies

Please list all medications that you are allergic to and the reaction you had when taking the medication.

Medication Allergies	Reaction
1.____________________	1. ____________________
2.____________________	2. ____________________
3.____________________	3. ____________________
4.____________________	4.____________________

Are you allergic to Albuterol and/or Xopenex nebulizer solution? Yes No

Have you had a flu shot? ___________ If so, when? ______________

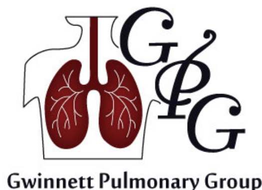
Have you had a pneumonia shot? ___________ If so, when? ______________

Family Medical History

Has anyone in your **family** ever been diagnosed with any of the following health conditions?
Please indicate which family member was affected in the space provided.
Family Members Included: Mother, Father, Brother, Sister, Son, Daughter, Aunt, Uncle, and Grandparent

Health Condition	Family Member(s)
1. COPD	1.
2. Emphysema	2.
3. Asthma	3.
4. Pulmonary Fibrosis	4.
5. Pulmonary Hypertension	5.
6. Blood Clots	6.
7. Bleeding Disorders	7.
8. Sleep Apnea	8.
9. Narcolepsy	9.
10. Restless Leg Syndrome	10.
11. Alpha-1 Antitrypsin Deficiency	11.
12. Cancer (please indicate what type of cancer)	12.
13. Heart Attack	13.
14. Congestive Heart Failure	14.
15. Coronary Artery Disease	15.
16. High Cholesterol	16.
17. Stroke	17.
18. High Blood Pressure	18.
19. Diabetes	19.
20. Thyroid Problems	20.
21. Other	21.

631 Professional Drive, Suite 350, ● Lawrenceville, GA 30046 Phone: 770-995-0630
3855 Pleasant Hill Road, Suite 180 ● Duluth, GA 30096 Fax: 770-995-1555



Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C

Board Certified

Pulmonary Medicine
Critical Care
Sleep Medicine

Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.
Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Susan Mucha, M.D.

NAME: Date of Birth:

Past Medical History

What health condition(s) have **YOU** been diagnosed with?
Please indicate with a check mark beside the condition.

______1. COPD
______2. Emphysema
______3. Asthma
______4. Pulmonary Fibrosis
______5. Pulmonary Hypertension
______6. Blood Clots (when/where) _______
____
______7. Bleeding Disorders
______8. Sleep Apnea
______9. Narcolepsy
_____10. Restless Leg Syndrome
_____11. Alpha-1 Antitrypsin Deficiency
_____12. Other ______________________________

_____13. Cancer (cancer type/when)
____
____
____
_____14. Heart Attack (when) ______________
_____15. Congestive Heart Failure
_____16. Coronary Artery Disease
_____17. High Cholesterol
_____18. Stroke (when) _______________________
_____19. High Blood Pressure
_____20. Diabetes
_____21. Thyroid Problems
_____22. Other ______________________________

Please list all surgeries that you have had in the past.

Date	Procedure
1.________________	1.____
2.________________	2.____
3.________________	3.____
4.________________	4.____
5.________________	5.____
6.________________	6.____

Social History

1. Do you drink alcohol?

_____ no I do not drink alcohol _____ no I do not drink alcohol now, but I did in the past

_____ yes I drink alcohol (circle one) occasionally, once weekly, once monthly, daily, other

Circle One: Beer Wine Hard Liquor Mixed Drinks

2. What is your living situation, or who do you live with?

_____ I live alone

_____ I live with: (circle one) spouse – parent(s) - son - daughter - domestic partner – roommate

Other ____

Name and daytime phone for this person: ______________________________________

Do you have any pets: ____

631 Professional Drive, Suite 350, ● Lawrenceville, GA 30046
3855 Pleasant Hill Road, Suite 180 ● Duluth, GA 30096
Phone: 770-995-0630
Fax: 770-995-1555

NAME: Date of Birth:

Social History

3. Do you use tobacco products?

_____yes I smoke cigarettes. I started smoking at age ______. At most I smoke _____ packs per day and on average I smoke _____ packs per day.
_____yes I use smokeless tobacco now and have for ________ years
_____no I have never used tobacco products
_____no I do not smoke cigarettes now. I started smoking at age ______. I quit smoking at age ______. In the past I smoked **at most** ________packs per day and **on average** _____ packs per day.
_____ no I have never used tobacco products, but I have lived with someone who smoked indoors (circle one) now / in the past

4. What is your occupation?

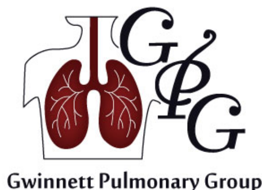
_____ I am currently retired. Prior to this, I worked as a ____
_____ I am currently working (circle one) full-time/part-time as a____
_____ I am currently unemployed. Prior to this, I worked as a ____
_____ I am currently on disability. Prior to this, I worked as a ____

5. Please indicate if you have ever been exposed to smoke, fumes, dust, asbestos, etc in previous occupations.

Medications

Please list all medications including strength and how many times you take the medication daily (use back if needed)

1.____________________ 11.____________________
2.____________________ 12.____________________
3.____________________ 13.____________________
4.____________________ 14.____________________
5.____________________ 15.____________________
6.____________________ 16.____________________
7.____________________ 17.____________________
8.____________________ 18.____________________
9.____________________ 19.____________________
10.____________________ 20.____________________



Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C

Board Certified

Pulmonary Medicine
Critical Care
Sleep Medicine

Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.
Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Susan Mucha, M.D.

NAME: Date of Birth:

Please answer questions 1 - 8 using the scale below.
Please circle the number that applies for you in each situation.

0 – would be never doze
1 – slight chance of dozing
2 – moderate chance of dozing
3 – high chance of dozing

Situation	Chance Of Dozing			
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place (meeting, movies, church)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking with someone	0	1	2	3
7. Sitting quietly after lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

Total: __________

Please answer the following questions by circling yes or no.

Question		
1. Do you snore?	YES	NO
2. Do you feel sleepy during the daytime?	YES	NO
3. Do you **NOT** feel refreshed when you wake up in the morning?	YES	NO
4. Have you been in a car accident / or a near miss situation due to you falling asleep at the wheel?	YES	NO

If you answered yes to any question above, please explain:

I,________________________________ have answered all questions in this medical questionnaire to the best of my knowledge and agree for Gwinnett Pulmonary Group to use the information provided to aide in making informed medical treatment decisions.

Signature:____ Date:_________________________

631 Professional Drive, Suite 350, ● Lawrenceville, GA 30046
3855 Pleasant Hill Road, Suite 180 ● Duluth, GA 30096
Phone: 770-995-0630
Fax: 770-995-1555

NAME: Date of Birth:

Medical Records Request

I hereby grant permission to the following health care professional or facility to release my medical records

____

____

____

____

to Gwinnett Pulmonary Group and:

Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C

Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.
Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Susan Mucha, M.D.

Please mail or fax the following records:

Complete Record___________________

X-Ray Report Only_________________

Lab Report Only___________________

X-Ray Films Only__________________

Other____________________________

Thank you for your cooperation in this matter.

Patient / Guardian Signature _______________________________________ Date ___________________

NAME: Date of Birth:

Release of Medical Information

I hereby grant permission to:

Lawrence Kaplan, M.D.	Rajesh Jasani, M.D.
Michael Sineway, M.D.	Prasad Garimella, M.D.
Paul Weinberg, M.D.	Sarah Hayat, M.D.
William McGann, M.D.	Vosudesh Pai, M.D.
Lynn Stewart, NP-C	Susmita Rajanala, M.D.
Opal Blake, NP-C	Susan Mucha, M.D.

to release any pertinent information to my insurance company or physician upon request, including diagnosis and medical records relating to any treatment or examination rendered to me during the period that I am a patient of these doctors.

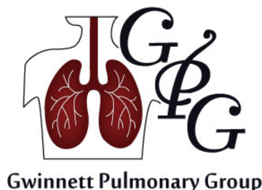
I further authorize and request that any insurance due me for services rendered by these doctors be paid directly to them in the event there is a balance owing on my account.

I hereby acknowledge that I am financially responsible for any and all charges or professional services rendered.

In connection with the use of the release and assignment, a photocopy shall be considered as valid as the original.

____ ______________________

Patient / Guardian Signature Date



Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C

Board Certified

Pulmonary Medicine
Critical Care
Sleep Medicine

Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.
Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Susan Mucha, M.D.

NAME: Date of Birth:

For **correspondence** of your medical information Gwinnett Pulmonary Group may **contact** you via: (please check all that apply)

Home Telephone #_________________________________
_____OK to leave message with detailed information
_____Leave message with call back number only

Work Telephone #__________________________________
_____OK to leave message with detailed information
_____Leave message with call-back number only

Written Communication
_____OK to mail to my home address
_____OK to mail to my work/office address
_____OK to fax to this number ________________________

Please list **relatives / friends** that you give Gwinnett Pulmonary Group permission to discuss your medical condition with. This includes but not limited to test or blood work results, physician's recommendations, etc.

1.____________________________________5.____

2.____________________________________6.____

3.____________________________________7.____

4.____________________________________8.____

In case of emergency Gwinnett Pulmonary Group should contact:

Name: ____ Phone: _______________________

I, _______________________________ give Gwinnett Pulmonary Group permission to discuss my medical condition with any person listed above.

Patient Signature: ____ Date: _____________________

631 Professional Drive, Suite 350, ● Lawrenceville, GA 30046
3855 Pleasant Hill Road, Suite 180 ● Duluth, GA 30096
Phone: 770-995-0630
Fax: 770-995-1555

Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C

Board Certified

Pulmonary Medicine
Critical Care
Sleep Medicine

Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.
Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Susan Mucha, M.D.

NAME: Date of Birth:

PAIN MEDICATION / NARCOTIC MEDICATION POLICY

Please read carefully and sign at the bottom. A copy will be provided to you upon request.

1. I agree to take narcotic medication exactly as instructed. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without first talking to my prescribing physician.
2. Narcotics will NOT be phoned in after business hours or on weekends.
3. Only ONE pharmacy will be used for filling narcotic prescriptions.
4. The following are conditions for immediate termination from the practice.
   a. Obtaining narcotics from any other physician while under our care without our knowledge.
   b. Altering or forging of a prescription is a felony and will be reported.
5. Patients may be terminated from the practice with 30 days' notice form noncompliance in the taking of their medication.
6. We will NOT refill prescriptions that have been lost or misplaced. Please be responsible in keeping up with your narcotic prescriptions.
7. Stolen medications will be replaced ONE TIME ONLY if you have a valid police report.
8. In the case of intolerance or ineffective narcotic medications, a different prescription could be given, provided the unused portion of the previously prescribed medication was returned.
9. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend AGAINST the operation of heavy equipment, which includes driving a motor vehicle. I am aware that if I choose to drive I could be charged with a DUI.
10. I have been informed about the use of narcotic adverse side effects such as the development of tolerance, dependence, addiction, withdrawal, constipation, nausea, itching, harmful effects to an unborn child, urinary retention, impairment of reasoning and judgment, and depression of breathing.
11. I will not combine any narcotic medications with the consumption of alcohol.
12. I will not give, trade or sell pain medications.
13. I will allow one (1) week for a prescription refill to be authorized.
14. **I understand there will be a $10.00 administrative fee charged if I do not have an appointment with the provider the day the prescription is picked up.**
15. I understand I must show proper valid ID to pick up prescription, if a caregiver is picking up the prescription, he/she must show proper valid ID in addition to my ID.

I have read and understand the above policy and agree to abide by its terms.

Patient Signature: ____ Date: __________________

Revised 5/2015

631 Professional Drive, Suite 350, ● Lawrenceville, GA 30046 Phone: 770-995-0630
3855 Pleasant Hill Road, Suite 180 ● Duluth, GA 30096 Fax: 770-995-1555