NAPS North Atlanta Pulmonary & Sleep Specialists

993 C Johnson Ferry Road, Suite 300
Atlanta, Georgia 30342
404-250-4530/ Fax: 404-252-8026

Robert J Albin, MD
David E Westerman, MD
Alex Hebert, NP-C

To our New Pulmonary Patient:

On behalf of North Atlanta Pulmonary & Sleep Specialists (NAPS), we welcome and thank you for choosing our practice. It is our desire to make your visit a pleasant one and to work with you to establish a positive treatment plan.

Please help us provide quality medical care by bringing the following items:

1. **All of your medications**. If you are unable to bring the medications, please bring a complete list, the dosage, and the number of times taken daily, including all over-the-counter medications.
2. Please bring **all Chest X-rays and/or CT Scan Films/CD's that have been taken in the last 2 years**. We do require you to bring the **actual film/CD** with you to your appointment in order to provide a complete examination.
3. If you have had any blood tests in the last year, please call to have the results faxed to us at (404) 252-8026.
4. **History and demographic forms** (enclosed or provided on our website).
5. **Insurance card**
6. **Government issued photo ID**
7. **Insurance Referral**, if a requirement of your insurance plan

If you have any questions or concerns prior to your appointment, please feel free to call our office at 404-250-4530 between the hours of 8:00 AM and 4:00 PM.

Thank you again for choosing North Atlanta Pulmonary & Sleep Specialists. We look forward to meeting you.

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CHEST X-RAY AND/OR CT SCANS

Dear Patient:

In order for your office evaluation to be optimal, it is important for us to have the most **current films and the radiology report at the time of your appointment.** Please bring any Chest X-ray films and/or CT scan disks that you have had in the last two (2) years.

You may have to contact either your physician's office or a hospital radiology film department in order to obtain these films. They will need to have minimum of 48-72 hours notice in order to provide copies.

Please have your physician's office **fax the radiology reports to our clinical department at (404) 252-8026.**

Thank you very much for your assistance in helping us make your visit as comprehensive as possible. If you have any questions regarding this request, please feel free to contact our clinical staff at (404) 250-4530.

Thank you again,

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IF YOU HAVE ANY OF THE FOLLOWING, PLEASE BRING TO APPOINTMENT

Tests done within past 2 years

- Echocardiogram/Heart catheterization
- Chest x-ray (film/CD **AND** report)
- CT scans of chest, abdomen, or thorax (film/CD **AND** report)
- Labwork

Tests/additional information EVER done

- Pulmonary Function Tests
- Cardio or Pulmonary stress tests
- Hospital records pertaining to condition
- Last progress note if ever been to pulmonologist

Medications

- Bring all medications to first visit OR
- A current list including the name of the medication, dosage, and number of times taken each day (please include all vitamins and over the counter medications in this list).

You may either arrange to pick up records/reports yourself or have them faxed to us at (404) 252-8026. Films will have to be retrieved in person from the office at which they were taken. We must have the actual radiology films/CDs in order to have a successful consultation.

If you are scheduled for a Complete PFT, please wear loose fitting clothing and do not use a rescue inhaler or smoke within 4 hours of the test. It is important not to eat a heavy meal within 3 hours of the test.

If you have any questions regarding these requests, please feel free to contact our clinical staff at (404) 250-4530.

Thank you for your assistance,

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NAPS North Atlanta Pulmonary & Sleep Specialists

Patient Account # _____

Patient Name _____ Date of Birth: _____

Patient email _____

Primary Phone Number _____ Cell Phone Number_____

Pharmacy Information:

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____

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Please help us provide the best medical care to you by completing this form and listing the medications that you are currently taking and the medications you are allergic to, if any. Please complete this form and bring it to your appointment.

Patient's Name: _____ DOB: _____

Please list the medications that you are currently taking: (include over-the-counter meds).

Medication Name:	Dosage amount:	Times taken per day:

Please list the medications that you are allergic to:

Thank you for your assistance in providing the above information.
Our goal is to provide you with the best medical care possible!

David Westerman, MD • Robert Albin, MD

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Name:	DOB:	Age:	Date:	Referring MD:	Primary MD:

Please help us find out about you by filling out the "Patient" side of this form on pages 1-3. If you don't know the answer to one of the questions, ask a family member to help you. ***Please leave the "Clinician" side blank***

PATIENT

Why are you here to see a pulmonary (lung) doctor?

_____
_____
_____

Check off any lung or breathing problems or symptoms:

- ☐ Wheezing
- ☐ Heart Murmur
- ☐ Unable to sleep laying flat or with only one (1) pillow
- ☐ Sudden onset of difficulty breathing
- ☐ Night sweats, fever, chills
- ☐ Coughed up blood
- ☐ Chest pains or pressure
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Swollen legs
- ☐ Heart failure or heart attack
- ☐ Blue lips or fingernails
- ☐ Leg cramps when you walk
- ☐ Cough
- ☐ Hoarseness
- ☐ Discolored sputum

Have you ever had:

- ☐ COPD
- ☐ Asthma
- ☐ Pneumonia or bronchitis
- ☐ Blood clot in your leg or lung
- ☐ Exposure to tuberculosis or had tuberculosis
- ☐ Lung cancer
- ☐ Lung surgery
- ☐ Bronchoscopy or bronchial/lung biopsy
- ☐ Allergy shots or allergy testing
- ☐ Pulmonary function or spirometry test
- ☐ Pulmonary stress test
- ☐ Chest x-ray or CT scan of chest

Are you being treated now or have you been treated for any illnesses? Please list them.

1.
2.
3.
4.
5.
6.
7.
8.

Have you had any operations? Any injuries? Please list them.

1.
2.
3.
4.
5.

Health Habits:

Have you ever smoked? ☐ Yes ☐ No ☐ Current
How many packs per day? _____
For how many years? _____
If you no longer smoke, when did you quit? _____
Lived with someone who smokes? ☐ Yes ☐ No
How much alcohol do you drink? _____
Do you use any recreational drugs? ☐ Yes ☐ No
List: _____

CLINICIAN

CC

HPI

PAST MEDICAL HISTORY

Past Med Hx

Past Surg Hx

PATIENT	CLINICIAN

Marital Status S M W D

Social Hx

With whom do you live?_____

What is your occupation?_____

List past occupations: _____

_____

_____

What are your leisure activities (hobbies)? _____

_____

What is your education level?_____

Place of birth?_____

Recent travel outside of Southeast:_____

_____

Please check if you have:

Occ Hx

☐ Worked around toxic chemicals or substances
☐ Asbestos or silica exposure

Do you exercise (including walking) regularly?

☐ Yes ☐ No Describe_____

_____

_____

Has a close family member had lung cancer, tuberculosis, emphysema or chronic bronchitis?

☐ Yes ☐ No Who? _____

Family History

Family Hx

	Living	Age	Medical Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Are you allergic to any medications? ☐ Yes ☐ No

Allergies

1.
2.
3.
4.
5.

Do you have allergies to pets, mold, grass, pollen, etc? ☐ Yes ☐ No

What kind of symptoms do you experience?

_____

_____

_____

Have you had the following vaccines?

Vaccinations

☐ Influenza ("Flu Shot") Annually When: _____

☐ Pneumococcal ("Pneumonia") Vaccine When: _____

PATIENT	CLINICIAN

Please tell us about your medicines (names, dose or strength, how many times per day). Include over-the-counter medications, birth control pills, vitamins, aspirin and herbs.

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

Medicines

Please circle all symptoms you have:

REVIEW OF SYMPTOMS AND SYSTEMS

☐ Lack of energy, daytime sleepiness, trouble sleeping, snoring, loss of appetite, weight changes, fevers — Constitutional

☐ Eye problems, such as double or blurred vision, glaucoma, cataracts

☐ Hearing problems, buzzing or ringing in ears

☐ Sinus problems — HEENT

☐ High blood pressure or palpitations — Cardiac

☐ Stomach problems, heartburn, indigestion, change in bowel habits, choking on food

☐ Bloody or tarry stools, jaundice, liver problems, ulcers, gallstones, diverticulitis — Digestive

☐ Urinary problems: Frequency, infections, stones, bladder

☐ Men: Prostate problems, night-time urination

☐ Women: Abnormal menstrual periods, pregnant — Urinary

☐ If you are a woman, have you passed menopause?
☐ Yes ☐ No At what age? _____

☐ Do you take estrogen replacement? ☐ Yes ☐ No

☐ Kidney disease

☐ Joint pain, swelling or redness, arthritis, back pain

☐ Muscle aches or tenderness, gout — Musculoskeletal

☐ Rash, itching or other skin problems — Dermatological

☐ Paralysis (even temporary); stroke, numbness, loss of balance

☐ Seizures, loss of memory, headaches, loss of consciousness — Neurological

☐ Unusual thoughts, nervousness, crying or sadness, depression — Psychiatric

☐ Thyroid disorder, diabetes, excess thirst, hunger or urination — Endocrinology

☐ Bleeding, easy bruising, risk factors for HIV, anemia, cancer — Hematological

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AUTHORIZATION TO RELEASE INFORMATION

Name: _____ DOB: _____ SSN: _____

PLEASE SEND INFORMATION TO:

_____ Attention: _____ Phone: _____
Name of Provider/Clinic/Organization

_____ Fax: _____
Street Address

_____
City, State, Zip Code

I AUTHORIZE the following information to be disclosed by: _____
(Please check all that apply)

_____ Entire Record
_____ The medical records concerning the time period of: _____.
_____ Operative/Procedure Notes
_____ Biopsy reports
_____ Labs
_____ Office notes
_____ Pathology reports
_____ CDs of Imaging studies (CT, PET, MRI)
_____ Imaging study reports (x-rays, etc.)

This information is requested for the purpose of: _____

_____

ADDITIONAL PATIENT INFORMATION:

- **I understand that if the office has not received my records by the date of my appointment, my appointment can or may be rescheduled.**
- I understand that I do not have to sign this authorization to get treatment.
- I understand that this request can take up to five (5) business days to process.
- I understand that the medical records to be released may contain information related to HIV status, AIDS, alcohol or drug use, or mental health services and I hereby authorize release of this information.
  Please note: this authorization does NOT permit release of psychotherapy notes.
- I understand that under Georgia law OCGA 31-33-3, the party requesting the patient's records may be charged a reasonable cost for reproducing the requested records. Reasonable costs are determined by the Office of Planning and Budget for the State of Georgia.
- I understand this authorization for release of information is valid for a period of (1) year and may be withdrawn by me at any time except during an action taken in response thereon. I may revoke this authorization by submitting a written request to:

  _____
- I understand that there is a potential that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be subject to protections under the federal privacy regulations.

_____ Date: _____
Patient' Signature (Parent or Legal Representative, if applicable)

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize redisclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse, the following notice shall also apply.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFS Part 2). The Federal rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict the use of any of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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404-303-1700 • Fax 404-252-9527
General Fax 404-236-8053

DIRECTIONS TO OFFICE:

TRAVELING EAST ON 1-285: EXIT 26 -Glenridge-Johnson Ferry.
Turn right and get in the left lane and come to the first stoplight. Turn left on Johnson Ferry Road. Go to the second light and turn right on Meridian Mark Road at the SunTrust Bank. Come to the first light and turn right. You will see the signs for Building C Parking. Building C is on your left as you drive in.

TRAVELING WEST ON 1-285: EXIT 28 Peachtree Dunwoody Rd.
Turn left onto Peachtree-Dunwoody Road. Come to the fourth light and turn right on Johnson Ferry Road. (You will see Northside Hospital on your right), come to the next light and turn left on Meridian Mark Road at the SunTrust Bank. Then turn right at first light, you will see signs to Building C Parking.

TRAVELING SOUTH ON GA 400: EXIT at the Glenridge Connector.
Proceed to the end of the ramp and tum right. Go to the second light and turn left onto Meridian Mark Road. Turn left at the first light into the Northside Hospital Professional Buildings. You will see the signs for Building C parking.

TRAVELING NORTH ON GA 400: EXIT at the Glenridge Connector.
Turn right off the exit ramp. At the first light, turn left onto Meridian Mark Road. Turn left at the first light into the Northside Hospital Professional Buildings. You will see the signs for Building C parking.