CHEST MEDICINE ASSOCIATES
The Pulmonary • Critical Care • Sleep Medicine Specialists

Welcome to Chest Medicine Associates

Chest Medicine Associates is a medical practice devoted to specialty care in Pulmonary, Critical Care and Sleep Medicine. Our physicians and staff are committed to providing exceptional quality care, prompt medical attention, and a personalized approach to health care problems. Our physicians and advanced practice providers are trained to prevent, diagnose, and treat lung diseases and sleep disorders.

We welcome you to our practice and are pleased that you and your referring physician have chosen Chest Medicine Associates for your medical care.

_____ has requested a consultation

appointment for you at our office for your pulmonary / sleep care.

Your appointment is scheduled for:

A questionnaire about your health and medical history is enclosed. Please complete and return it to our office as soon as possible. You can mail the completed questionnaire in the enclosed addressed envelope. Or, if you prefer, you can fax it to us at 207-828-0188. **It needs to be returned at least 3 business days prior to your appointment or you may have to reschedule your visit.**

If you would like to learn more about our practice, please visit our website at **www.cmamaine.com**.

If you have any questions or need to change the scheduled appointment, please call our office at 207-828-1122.

Thank you again for choosing us to provide your care.

Sincerely,

Chest Medicine Associates

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Directions to Chest Medicine Associates

100 Foden Road, West Building, Suite 103
South Portland, Maine 04106

Free parking is available on-site.

FROM THE MAINE TURNPIKE, NORTH OR SOUTH – Toll Road (95)
Take Exit 46 toward ME-22/ME-9/Jetport/Congress St. Turn right toward Johnson Rd/ME-9 West. Turn right at Johnson Rd/ME-9 West. Continue straight for 0.9 miles and at the third light turn right onto Foden Road. After driving a short distance turn left into 100 Foden Road.

FROM CUMBERLAND FORESIDE – Interstate (295)
Head south on Foreside Road/State Route 88. Bear right at Kings Highway and take first right towards US-1 South. After half a mile, turn left at US-1 South. Follow road until it merges with I-295 South. Once on I-295 South, take exit 3 for ME-9/Westbrook Street. Turn right onto Westbrook Street. At second light, turn right onto Western Avenue. Once on Western Avenue, at the first light, take a left onto Foden Road. 100 Foden Road will be on your left.

FROM BUXTON
Head southeast on Long Plains Road/ME-22. Turn slight left onto Portland Road/ME-22 and follow for approximately eight miles. Turn right onto Skyway Drive. Follow for approximately half a mile and turn right onto Western Avenue. Follow this road for approximately one mile, and turn right onto Foden Road. 100 Foden Road will be on your left.

FROM MAINE MEDICAL CENTER (BRAMHALL STREET) – Interstate (295)
Head northeast on Bramhall Street toward Hill Street. Turn left onto Congress Street. After half a mile, turn right at St. John Street. Turn left onto Park Avenue. Take slight right to merge onto I-295 South/US-1 South toward South Portland. Follow this road for two miles. Take exit 3 for ME-9/Westbrook Street. Turn right onto Westbrook Street. At second light, turn right onto Western Avenue. Once on Western Avenue, at the first light, take a left onto Foden Road. 100 Foden Road will be on your left.

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PATIENT REGISTRATION

Patient: _____

Male: ☐ *Female:* ☐ *Date of Birth:* _____/_____/_____ *Age:* _____

Address: _____

City/Town: _____ *State:* _____ *Zip Code:* _____

Home Telephone: _____ *Daytime Telephone:* _____

Email: _____ *Social Security Number:* _____-_____-_____

☐ *I refuse to enroll in the Chest Medicine on-line patient portal*

Ethnicity: ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino* ☐ *Other*

Race: ☐ *African American* ☐ *Asian* ☐ *Indian* ☐ *Native American*

☐ *Caucasian (White)* ☐ *Other* _____

Language: ☐ *English* ☐ *Other* _____ *Interpreter Needed?* ☐ *Yes* ☐ *No*

Primary Care Physician: _____ *Telephone:* _____

Primary Insurance: _____ *Policy #:* _____

Secondary Insurance: _____ *Policy #:* _____

Is your visit covered under Workman's Compensation? ☐ *Yes* ☐ *No*

Pharmacy _____*Address*_____

Emergency Contact: _____ *Relationship:* _____ *Phone:* _____

*I give permission for*_____*to receive/discuss information regarding my care with Chest Medicine Associates medical staff.*

I acknowledge receipt of the Notice of Privacy Practices prepared by Chest Medicine Associates. Also, I acknowledge that I have had an opportunity to ask questions about the practice's Notice of Privacy Practices (See Pamphlet Enclosed).

_____ _____

Patient Signature *Date*

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Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs, we will work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered to you.

- Bring your insurance card(s) at every visit.
- ***Be prepared to pay your copay and any outstanding balance at each visit.*** Payment may be made by cash, check, debit card, Visa, Master Card, Discover or American Express.
- ***Self-pay patients will be expected to bring $100.00 to their initial appointment for a Consultation Visit or a Pulmonary Function Test.*** If you do not have insurance, you will be asked to make payment arrangements for the balance.
- If you have insurance in which we do not participate, our office will file the claim on your behalf. ***It is your responsibility to verify provider's participation status with your insurance company's member services department (number is on your insurance card).***
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us prior to the visit.
- It is your responsibility to bring any required referrals for treatment ***at, or prior to, the visit***. If you do not have the referral, you may be financially responsible.
- If the patient is a minor (less than 18 years old), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service and should bring the necessary referrals and insurance card.

If you have questions about your insurance, we are happy to assist you. Specific coverage issues, however, should be directed to your insurance company's member services department (number is on your insurance card.) **It is the patient's responsibility to verify if there are any benefit or pre-existing exclusions on their policy.**

If you ever need to cancel or reschedule an appointment, we ask that you kindly notify us at least 24 hours before your appointment so that we may offer the appointment to someone else who needs our services.

If you do not show up for your appointment without providing at least 24 hours' notice, you will be charged the following fees (exceptions for extenuating circumstances may be made at our discretion):

Sleep study: $250
Consultation Visit or Pulmonary Function Test: $50
Behavioral Sleep Medicine Services $50

We will assess a $25.00 service fee for any checks returned unpaid. If your payment is not received within 30 days of the statement date, your account will be considered delinquent. If your account is delinquent, we will turn your account over to a collection agency and may list your default with credit reporting agencies.

Our practice firmly believes that a strong physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the Chest Medicine Associates Business Office at 207.828.0493.

I have read the above Financial Policy and agree to its terms.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name Date of Birth

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Last Name:	**First Name:**
Date of Birth:	

Reason for Visit: _____

Do you have any of the following symptoms? Please check (√) NO or YES:

Constitutional
Chills ___NO ___YES
Fatigue ___NO ___YES
Fevers ___NO ___YES
Insomnia ___NO ___YES
Night sweats ___NO ___YES

Eyes/Ears/Nose/Throat/Mouth
Itchy eyes ___NO ___YES
Watery eyes ___NO ___YES
Nasal congestion ___NO ___YES
Frequent sneezing ___NO ___YES
Hoarseness ___NO ___YES
Post nasal drip ___NO ___YES
Snoring ___NO ___YES

Respiratory/Lungs
Cough ___NO ___YES
Shortness of breath ___NO ___YES
Coughing up blood ___NO ___YES
Sharp pain w/ breathing ___NO ___YES
Coughing up mucus ___NO ___YES
Wheezing ___NO ___YES
Tuberculosis exposure ___NO ___YES
Positive TB skin test ___NO ___YES

Cardiovascular/Heart
Chest pressure/pain ___NO ___YES
Swelling in legs/feet ___NO ___YES
Short of breath lying flat ___NO ___YES
Palpitations ___NO ___YES

Gastrointestinal
Trouble swallowing ___NO ___YES
Heartburn ___NO ___YES
Reflux ___NO ___YES

Genitourinary
Blood in urine ___NO ___YES
Night time urination ___NO ___YES

Metabolic/Endocrine
Recent weight gain ___NO ___YES
Amount ____ pounds
Recent weight loss ___NO ___YES
Amount ____ pounds

Neurologic/Psychiatric
Morning Headaches ___NO ___YES
Memory problems ___NO ___YES
Difficulty concentrating ___NO ___YES
Anxiety ___NO ___YES
Depression ___NO ___YES
Sleep disturbance ___NO ___YES

Skin
Rash ___NO ___YES
Itching ___NO ___YES

Musculoskeletal
Joint pain ___NO ___YES
Joint swelling ___NO ___YES
Muscle aches ___NO ___YES
Muscle weakness ___NO ___YES

Hematologic
Easy bleeding ___NO ___YES
Easy bruising ___NO ___YES

Immunology
Hay fever ___NO ___YES
Hives ___NO ___YES

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Allergies

Drug/Food/Environment	Type of Reaction

Prescription Medications

Drug	Dosage Strength	Frequency

Non-Prescription/Over the Counter (OTC) Medications/Herbal Remedies/Vitamins

Drug	Dosage Strength	Frequency

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Personal and Family Histories: Please check (√) all that apply

	Self	Family		Self	Family
Anemia			High cholesterol		
Asthma			HIV		
Cancer Type:			Hypertension		
COPD (chronic bronchitis or emphysema)			Collapsed Lung (pneumothorax)		
Cystic Fibrosis			Pulmonary embolism		
Depression/Anxiety			Pulmonary fibrosis		
Diabetes			Pulmonary hypertension		
Heartburn/Reflux			Sarcoidosis		
Heart disease			Seizures		
Heart failure			Sleep apnea		
Heart valve problem Type:			Stroke		
			Tuberculosis		
Other:					

Surgical History

Please list any surgeries or procedures that you have had:

_____
_____
_____
_____

Social History

Occupation: _____

Previous or Current Occupational Hazards:
___None known ___Dust ___Asbestos ___Toxic fumes
___Toxic chemicals Other: _____

Marital Status: _____
Smoking Status:
___ Never ___ Current Smoker ___ Former Smoker
_____ Packs per day _____ Packs per day Year quit _____
_____ Years smoked _____ Years smoked

Alcohol use: Type: _____ Average # drinks /week _____
___NO ___YES

Caffeine use: Daily amount:_____
___NO ___YES

Please check the type of heating system in your home:

___ Electric baseboard
___ Hot water baseboard
___ Radiant
___ Forced hot air
___ Kerosene Monitor
___ Wood stove

Other: _____

Do you exercise on a regular basis? ___NO ___YES Type: _____

Pets in home:

___ None
___ Bird
___ Rodents
___ Farm Animals
___ Dog
___ Cat

Current Recreational Drug Use:

___NO ___YES Type: _____

Advanced Directives

___ None ___ Living Will ___ DNR ___Other Directive

Heath Care Proxy: _____
Relationship: _____
Phone Number: ( ) _____
Address: _____
_____
_____

Patient Signature: _____ **Date**:_____

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Epworth Sleep Score

How likely are you to fall asleep or doze off in the following situations?
Even if you have not done some of these things recently, try to estimate how they would affect you.

Please place a check (√) in the appropriate box.

	Never	*Sometimes*	*Usually*	*Almost Always*
Sitting and reading				
Watching TV				
Sitting quietly after lunch (without alcohol)				
Sitting and talking with someone				
Sitting, inactive in a public place (like a movie or meeting)				
As a passenger in a car for an hour without a break				
In a car, as the driver, stopped for a few minutes in traffic				
Lying down to rest in the afternoon				

Name: _____ *Date:* _____

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