Pulmonary & Sleep Assoc SJ, Affiliate of Virtua Medical Group

Pulmonary Medicine Critical Care Medicine Sleep Medicine

Patient Information

Name:	**Referred by:** ____self ____ physician ____ seen in hospital ____ family/friend ____ current patient
Address: **City:**_____ **St**_____ **Zip**_____	**Date of Birth:**
Email:	**Social Security #:**
Home Phone #( )	**Gender:** ____**Male** _____**Female**
Cell Phone #( )	**Marital Status:**
Work Phone #( )	**Ethnicity:**
Emergency Contact Name:	**Employer:**
Emergency Contact Phone:	**Employment Status:**

Primary Insurance:	**Secondary Insurance:**
Identification #:	**Identification #:**
Policyholder's name if not patient (i.e. spouse)	**Policyholder's name if not patient (i.e. spouse)**
Date of Birth:	**Date of Birth:**
Social Security #:	**Social Security #:**
Relationship to Patient:	**Relationship to Patient:**

Assignment and release: I hereby authorize my insurance benefits to be paid directly to Virtua Medical Group. I understand that I am responsible for charges as designated by my insurance company/companies such as deductibles, co-pays, coinsurance, etc. I am also responsible for any and all charges not covered by my insurance. I authorize Virtua Medical Group to release any information to my insurance company/companies when requested.

Signature_____ DATE:_____

Pulmonary & Sleep Associates of SJ, a Virtua Affiliate

107 Berlin Rd.
Cherry Hill NJ 08034
856-429-1800

750 Rt. 73 Ste 401
Marlton NJ 08053
856-375-1288

1113 Hospital Drive Ste 305
Willingboro NJ 08046
856-375-1288

Patient Name: _____ **Date of Birth:** _____
Primary Care Doctor _____
Address: _____
Referring Doctor _____
Address: _____
Preferred Radiology: _____ **Preferred Lab:** _____
Preferred LOCAL Pharmacy: (name & address) _____
Preferred MAIL Pharmacy: (name & address) _____

Reason for visit: _____

Any recent hospitalizations Y / N Where: _____
Reason: _____

SYMPTOMS: (Please circle any symptoms you are experiencing today)

Fever	Cough	Trouble Falling Asleep
Chills	Mucous/Phlegm	Trouble Staying Asleep
Night Sweats	Hemoptysis	Non-restorative sleep
Fatigue	Acid Reflux	Grinding Teeth
Headaches	Muscular Weakness	Hallucinations as you fall asleep
Lightheadedness	Muscle Pains	Sleep Paralysis
Nasal Congestion	Joint Pains	Sudden loss of muscle tone
Chest Pain	Swollen Joints	Excessive Daytime Sleepiness
Chest Tightness	Anxiety	Snoring
Trouble breathing lying down	Depression	Witnessed Apneas
Swollen Legs/Feet	Insomnia	Seasonal Allergies
Shortness of breath at rest	Sleepwalking	OTHER:
Wheezing	Sleep talking	OTHER:

Patient name / DOB:_____

Medications: (Please include dosing or attach list)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies: (Please include reaction.)

_____ _____
_____ _____
_____ _____
_____ _____

Immunizations:

Pneumonia Vaccine Yes / No
Date Received: _____
Covid Vaccine Yes / No
Date Received: _____

Flu Vaccine Yes / No
Date Received: _____

Family History

Please indicate either living or deceased for the following family members and cause of death when applicable.

Mother L / D _____
Father L / D _____
Brother/Sister L / D _____
Brother/Sister L / D _____
Brother/Sister L / D _____
Brother/Sister L / D _____

Have any blood relatives ever had any of the following conditions? If so, who?

Diabetes: _____
Heart Disease: _____
High blood pressure: _____
Cancer: _____
High Cholesterol: _____
Multiple Sclerosis: _____

Past Medical History

Pulmonary & Sleep Problems/Illnesses: (Please include date if not current.)

Abnormal CXR/CT	**Hemoptysis**	**Pneumothorax**
Asbestosis	**Lung Cancer**	**Pulmonary Embolism**
Asthma	**Lung Nodule**	**Pulmonary Fibrosis**
Bronchitis	**Pleural Effusion**	**Pulmonary Hypertension**
Bronchiectasis	**Pleurisy**	**Sarcoidosis**
COPD/Emphysema	**Pneumonia**	**Tuberculosis**
Cough	**Obstructive Sleep Apnea**	**Restless Leg Syndrome**
Empyema	**Insomnia**	**Narcolepsy**

Others not listed: _____
_____

Patient name / DOB:_____

Past Medical History & Diagnoses: (Please circle any condition you have received treatment for)

Acid Reflux	Hepatitis
Atrial Fibrillation	Hypertension
Breast Cancer	Kidney Disease
Congestive Heart Failure	Cancer
Coronary Artery Disease	Seizures
Depression	Headaches/Migraines
Diabetes	

Others not listed: _____

_____

Surgical History

(Please circle/list all procedures/surgeries and the year you had them)

Appendectomy	Cholecystectomy	Knee Replacement
Bronchoscopy	Gastric Bypass	Lung Biopsy
Cardiac Bypass Surgery	Hernia	Lung Resection
Cardiac Catheterization	Hip Replacement	Tonsillectomy
Cardiac Valve Replacement	Hysterectomy	
Cardioversion		

Social History

Occupation:
Marital Status:
Any hazardous exposures (mold, asbestos, etc):
Where were you born:
Any Recent Travel: Yes / No Where : When:
Any Pets: Yes / No Kind:
Smoking: Current / Former / Never Duration in years: Packs per day:
Quit: Yes / No Year quit: Years smoked:
2nd hand smoke exposure:
Cigar Smoker: Vape:
Alcohol Use: Yes / No Number / Week: Any history of abuse:
Drug Use: Yes / No Type:
Diet: Yes / No Type: Weight loss / Cardiac / Diabetic / Other (list)
Regular exercise: Yes / No

Patient name / DOB:_____

Sleep / Home Equipment

Oxygen	Since:	How many liters/minute:
Cpap/BiPap	Since:	Settings if known:
Nebulizer	Since:	Used (circle): albuterol, ipratropium-albuterol, xopenex, pulmicort, Brovana, perforomist
Name of equipment Supplier(Company)		Phone number:

Pulmonary and Sleep Associates of South Jersey
Affiliate of Virtua Medical Group

____ Steven Baumgarten, M.D.	____ John Bermingham, D.O
_____Micheal Driscoll, D.O,	____ David Baumgarten, M.D.
_____Ira Horowitz, M.D.	____ Aaron Crookshank, M.D.
_____Thomas Nugent, M.D.	____ Thomas Grookett, M.D.
_____Alan Pope, M.D.	____ William Morowitz, M.D.
_____Antonio Velasco, D.O.	_____Nicholas Roy, D.O.

MEDICAL RECORDS RELEASE FORM

_____ _____
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to Pulmonary and Sleep Associates –Affiliate of Virtua Medical Group.

_____

Physician or Facility
Name:_____

Phone:_____Fax:_____

Medical information
requested:_____

Dates of Service:_____

Radiology
studies:_____

Please send (fax) to the physician office (Circled) below:

CHERRY HILL
107 Berlin Road
Cherry Hill, NJ 08034-3526
Phone: 856-429-1800
FAX: 856-429-1081

MARLTON/WILLINBORO
750 Route 73 South Suite 401
Marlton, NJ 08053-4145
Phone: 856-375-1288
FAX: 856-375-2325
Alternate fax #_____

_____ _____
Signature of Patient or Legal Guardian Date