

## Welcome to Pulmonary & Sleep Associates of South Jersey, an affiliate of Virtua Medical Group

**Cherry Hill:** 107 Berlin Rd. Cherry Hill, NJ 08034

Phone: 856-429-1800

Fax: 856-429-1081

**Marlton:** 750 Rt. 73 South, Suite 401 Marlton, NJ 08053

Phone: 856-375-1288

Fax: 856-375-2325

**Willingboro:** 1113 Hospital Drive, Suite 305 Willingboro, NJ 08046

Phone: 856-375-1288

Fax: 856-375-2325

Please find your new patient paperwork, required forms, and directions to our office attached to this packet. Please fill out ALL attached paperwork, completely and to the best of your ability, PRIOR to arriving to your scheduled appointment. **Please plan to arrive 30 minutes prior to your scheduled appointment time to allow time for registration.**

### **Please bring the following items with you to your appointment:**

1. Completed forms, new patient paperwork. You may attach a list of your medications for your convenience.
2. Photo ID (Driver's license, Passport, Non-driver ID, Military ID)
3. Insurance card(s)
4. Prescription plan card(s)
5. **REFERRAL**, if required by your insurance, sent electronically or faxed to our office by your Primary Care Provider prior to your scheduled appointment. Our NPI number is **1649226515**. If you DO NOT obtain a referral, we will either reschedule your appointment or if you choose to be seen, ask that you sign an **ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**. You may have a personal responsibility for all, part, or none of the cost of these outpatient services.
6. **Patients for Pulmonary Consult:** bring your Chest X-RAY and/or CAT scan films or CD. DO NOT use short acting inhalers/nebulizer medications up to four (4) hours prior to your first appointment. DO NOT use long acting medications (Spiriva, Advair, ect) up to 12 hours prior to your first appointment. Please remove dark nail polish and/or acrylic nails on one finger to allow us to measure your oxygen saturation at your appointment.
7. **Patients for Sleep Consult:** Please complete sleep disorder survey (attached). If you have had a Sleep Study in the past, please bring a copy to your appointment or have results faxed to our office prior to your appointment (fax numbers are stated above). If you are on CPAP / BiPAP therapy, please bring the chip from your machine to your appointment.

Pulmonary & Sleep Associates of South Jersey, an Affiliate of Virtua Medical Group greatly appreciate your courtesy in keeping all appointments and arriving at the requested time. If you are late, we may need to reschedule your appointment for another date or time.

Please give at least 24 hour notice to cancel or reschedule any appointments.

Co-pays are due at time of appointment.

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**Pulmonary and Sleep Associates of South Jersey, LLC**  
107 Berlin Road, Cherry Hill, N.J. 08034

**(Directions to the Cherry Hill Office)**

**Directions from Route 70 West:**

Take right onto jug handle to Kings Highway. Make left onto Kings Highway and cross over Route 70 to Brace Road south. Continue on Brace Road (NJ-154). At the 4<sup>th</sup> traffic light make a right onto Haddonfield Road (CR-561). Office is about ¼ mile down on the right.

**Directions from Route 70 East:**

Pass Ponzio's diner. Take 2<sup>nd</sup> right onto Brace Road (NJ-154). Continue on Brace Road. At the 4<sup>th</sup> light make a right onto Haddonfield-Berlin Road (CR-561). Office is about ¼ mile down on the right.

**Directions from Camden, Pennsauken and Haddonfield:**

Take Ferry Avenue/Cr-603 east towards Collingswood. Ferry Avenue becomes Haddon Avenue through Collingswood/West and Haddonfield. After crossing Kings Highway in Haddonfield, continue in the left lane which becomes Haddonfield-Berlin Road. Office is about ¼ mile down on the left.

**Direction from Points South:**

Take 295 to exit 32-CR561/Haddonfield Berlin Road. At the end of the exit ramp make a left onto CR-561 towards Haddonfield. Continue straight on CR-561/Haddonfield-Berlin Road. After passing Brace Road (Centrum Shopping Center), office is about ¼ mile down on the right.

**Direction from Points North:**

Take 295 to exit 32-CR561/Haddonfield Berlin Road. At the end of the exit ramp make a right onto CR-561 towards Haddonfield. Continue straight on CR-561/Haddonfield-Berlin Road. After passing Brace Road (Centrum Shopping Center), office is about ¼ mile down on the right.

**PATIENT SIGNATURE ON FILE FORM**

**CONSENT FOR TREATMENT**

I am either the patient who is seeking treatment or I am the person who is authorized to seek treatment for the patient. I am seeking treatment from the physician's staff of Virtua Health and by signing this document I authorize them to provide medical care and treatment to me or the person on whose behalf I am signing.

**MEDICARE**

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Virtua Health for any services furnished to me by their physicians. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

**In order to comply with Medicare regulations, please answer the following questions:**

Are you or your spouse employed?	Y	N
Has treatment been authorized by the VA?	Y	N
Do you or your spouse have other insurance?	Y	N
Are you covered under the Black Lung Program?	Y	N
Are you disabled or have end stage renal disease?	Y	N
Is there Medigap coverage secondary to Medicare?	Y	N
Is illness/injury the result of an auto accident?	Y	N
Is there Insurance coverage primary to Medicare?	Y	N
Did illness/injury occur at work?	Y	N
Is there employer supplemental coverage secondary to Medicare?	Y	N

**MEDIGAP (MEDICARE AND SECONDARY INSURANCE)**

I request that payment of authorized Medigap benefits be made to either me or on my behalf to Virtua Health for any services furnished to me by their physicians. I authorize any holder of Medicare information about me to release to \_\_\_\_\_ (Name of Medigap Coverage) any information needed to determine these benefits payable for related services.

**COMMERCIAL ASSIGNMENT OF BENEFITS**

I authorize payment directly to Virtua Health for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the physicians. I understand and agree that I am financially responsible to the above party for charges not paid under my policy. I permit a copy of this authorization to be used in place of the original.

**GENERAL RELEASE OF INFORMATION**

Virtua Health may disclose any or all parts of my clinical records to any insurance company or companies, or in the case of Worker's Comp claims, to my past or present employer(s), for purposes of satisfying charges billed by Virtua Health. This authorization does not cover requests from other parties seeking information regarding my account.

**GUARANTEE OF ACCOUNT**

For and in consideration of services rendered by Virtua Health to the below and named patient, the undersigned (jointly and severally if more than one) guarantee payment of all charges incurred by all said patient in accordance with the policy of payment of such bills.

**PATIENT BILL OF RIGHTS**

I have received a copy of the Patient Bill of Rights.

**THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patients Agents Representative/Guarantor Signature (if applicable) \_\_\_\_\_



## AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth:     /     /

### PHONE AUTHORIZATION:

- Yes, you have my permission to leave medical information on my voice mail. Please list which daytime telephone number is best to leave a message.

(     ) \_\_\_\_\_

- No, you do not have my permission to leave medical information on my voicemail.

### CONTACT AUTHORIZATION:

To whom, other than yourself, may we speak with regarding your medical information?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

- I elect **NOT** to have any of my medical information shared at this time.

Signature: \_\_\_\_\_

Date:     /     /

*This authorization will be effective for 1 year and utilized for all Virtua Medical Group service lines. I have the right to withdraw or revise my permission at any time in writing.*

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

\_\_\_\_ Steven Baumgarten, M.D.  
\_\_\_\_ Micheal Driscoll, D.O.,  
\_\_\_\_ Ira Horowitz, M.D.  
\_\_\_\_ Thomas Nugent, M.D.  
\_\_\_\_ Alan Pope, M.D.  
\_\_\_\_ Antonio Velasco, D.O.

\_\_\_\_ John Bermingham, D.O  
\_\_\_\_ David Baumgarten, M.D.  
\_\_\_\_ Aaron Crookshank, M.D.  
\_\_\_\_ Thomas Grookett, M.D.  
\_\_\_\_ William Morowitz, M.D.  
\_\_\_\_ 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:

**CERRY 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

# Pulmonary & Sleep Assoc SJ, Affiliate of Virtua Medical Group

Pulmonary Medicine

Critical Care Medicine

Sleep Medicine

## Patient Information

<b>Name:</b>	Referred by: <input type="checkbox"/> self <input type="checkbox"/> physician <input type="checkbox"/> seen in hospital <input type="checkbox"/> family/friend <input type="checkbox"/> current patient
<b>Address:</b>	<b>Date of Birth:</b>
City: _____ St _____ Zip _____	
<b>Email:</b>	<b>Social Security #:</b>
<b>Home Phone #</b> ( )	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Cell Phone #</b> ( )	<b>Marital Status:</b>
<b>Work Phone #</b> ( )	<b>Ethnicity:</b>
<b>Emergency Contact Name:</b>	<b>Employer:</b>
<b>Emergency Contact Phone:</b>	<b>Employment Status:</b>

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

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.

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

Mother L / D \_\_\_\_\_

Father L / D \_\_\_\_\_

Brother/Sister L / D \_\_\_\_\_

Brother/Sister L / D \_\_\_\_\_

Brother/Sister L / D \_\_\_\_\_

Brother/Sister L / D \_\_\_\_\_

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:	
2 <sup>nd</sup> 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:

**ONLY TO BE FILLED OUT IF YOU ARE COMING FOR A SLEEP DISORDER**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please consult your bed partner when answering the following questions. Answer the questions as if you are describing your typical night or sleep pattern. In answering questions about frequency, you will need to check one of the following choices: *nightly, weekly, rarely, never.*

1. Are you allergic to any drugs? \_\_\_\_\_
2. Describe your sleep problem:  
\_\_\_\_\_  
\_\_\_\_\_
3. When did your sleep problem begin?  
\_\_\_\_\_ (mo/yr)
4. Have you ever had a sleep study performed?  
 Yes  No
5. My bed or sleeping surface is:  
 Standard Mattress  Waterbed  Futon  
 Other: \_\_\_\_\_
6. Sleep Habits:  
My ideal amount of sleep is \_\_\_\_\_ hours.

	During the week	During the weekend
I go to bed at	(time)	(time)
I get up at	(time)	(time)
I sleep	(hours)	(hours)

It usually takes me \_\_\_\_\_ minutes to fall asleep.

I usually wake up \_\_\_\_\_ times a night.  
Please explain what wakes you up:  
\_\_\_\_\_  
\_\_\_\_\_

If I wake up at night, it usually takes \_\_\_\_\_ minutes to fall back asleep.

I cannot get back to sleep once I wake up  
 Yes  No

I can sleep 2 hours or more at a time:

*Nightly, Weekly, Rarely, Never*

7. My occupation is: \_\_\_\_\_  
My job requires shift work  Yes  No  
My work hours are: \_\_\_\_\_

8. I snore:  
*Nightly Weekly Rarely Never*

9. My snoring started at age: \_\_\_\_\_
10. I snore in all positions:  Yes  No
11. My snoring has been described as:

*Mild Moderate Loud*

12. I stop breathing at night:  
 Don't Know  Yes  No
13. I have problems with my nose or nasal breathing:  
 Yes  No  
If "YES", please explain: \_\_\_\_\_

14. I have had nasal surgery:  Yes  No  
If "YES", please explain: \_\_\_\_\_

15. I have had a tonsillectomy:  Yes  No

*Nightly Weekly Rarely Never*

16. I wake up gasping, short of breath, wheezing or feeling I cannot breathe:

17. I wake up coughing

18. I wake up with my heart beating irregularly

19. I wake up with chest pain

20. I wake up with heartburn or a sour acid taste in my mouth

21. I wake up with a headache

22. I have a bed wetting problem

23. I fight sleep or fall asleep uncontrollable while sitting at meetings, watching TV, at the movies, in the car...

24. I fight sleep while at work or school

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Nightly Weekly Rarely Never

25. I fight sleep while driving

26. I have actually fallen asleep while driving a car  
 Yes  No

27. It seems that my mood, memory or thought processes have changed  Yes  No

28. Drowsiness is the greatest in the:  
*Morning Afternoon Evening*

29. After a typical night's sleep, I feel:  
*Refreshed Fairly Somewhat Very*  
*rested drowsy tired*

Nightly Weekly Rarely Never

30. I have been told I toss and turn to an extreme amount:

31. I flail or kick while sleeping

32. I have the feeling of "restless" legs

33. I am troubled at night by uncomfortable sensations in my legs

34. I wake up with muscle or joint aches or pains

35. Immediately after falling asleep, I dream

36. I dream during my naps

37. I experience vivid dream-like scenes upon waking up or falling asleep

38. I have been told that I behave strangely when not fully Awake

39. I feel like I cannot move after lying down, before going to sleep, when waking up or going to sleep

40. I feel sudden weakness in the knees, neck, jaw or arms when angry, sad, laughing or emotional

*Daily Weekly Rarely Never*

41. I have episodes of doing strange things without realizing it at the time or lose a period of time:

*Daily Weekly Rarely Never*

42. I take daytime naps  Yes  No

43. After a nap, I feel:  
*Refreshed Fairly Somewhat Very*  
*rested drowsy tired*

Nightly Weekly Rarely Never

44. I sleepwalk:

45. I talk or scream in my sleep

46. I am disturbed by nightmares

47. I grind my teeth when asleep

48. Within the last year, depression, anxiety or stress has interfered with my sleep  Yes  No

49. At bedtime I have difficulty falling asleep because of worries or thoughts racing through my mind  Yes  No

50. My sleep problem, in addition to those previous, has resulted in:  
 \_\_\_\_\_  
 \_\_\_\_\_

51. I exercise  Yes  No  
 If "YES", what kind, what time of day, and how often?  
 \_\_\_\_\_  
 \_\_\_\_\_

52. Is there any history in your family of difficulties with sleep, excessive daytime sleepiness or snoring?  Yes  No

If "YES", explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

53. Please list medicines tried for improving sleep or staying awake:

<i>Drug and Dose</i>	<i>Frequency</i>	<i>Started</i>	<i>Ended</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____