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 ACKNOWLEGEMENT 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.

Pulmonary and Sleep Associates of South Jersey
750 Route 73 South, Suite 401
Marlton, NJ 08053
Phone: 856-375-1288 Fax: 856-375-2325

Directions to Marlton Office

Directions from 295:

Take 295 to Exit #34A, merge onto NJ-70 E/Marlton Pike E towards Marlton. (About 2 miles) make slight right onto **Old Marlton Pike**. Take the ramp onto NJ 73. Pass the Promenade (on the left) and pass the light (Evesham Road). At the next traffic light make a left onto **Ardsley Drive** (there is no jug handle). Make a first right into Willow Ridge Office Park. Office is located in building #4 Suite 401.

Take 295 to Exit #36A, Route 73 South .Take the ramp onto NJ 73. Pass the Promenade (on the left) and pass the light (Evesham Road). At the next traffic light make a left onto **Ardsley Drive** (there is no jug handle). Make a first right into Willow Ridge Office Park. Office is located in building #4 Suite 401.

Directions from Route 73:

If headed North on Route 73: Right on **Ardsley Drive** (Target will be on your left)
Turn right into first driveway-**Willow Ridge Office Park.**
Office is located in building #4 Suite 401.

If headed South on Route 73: Left on **Ardsley Drive** (Target will be on your right)
Turn right into first driveway-**Willow Ridge Office Park.**
Office is located in building #4 Suite 401

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 INSURNCE)

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) _____

Virtua Health

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.	____ 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

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:

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 rested Somewhat drowsy Very 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 rested Somewhat drowsy Very 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:

Drug and Dose	*Frequency*	*Started*	*Ended*