



# PULMONARY PHYSICIANS OF SOUTH FLORIDA, LLC

NEW PATIENT REGISTRATION FORM

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

Patient's Name (Last, First, MI) : \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F  M

Marital Status:  Married  Single  Divorced  Widowed

Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone:

Primary Care Physician: \_\_\_\_\_ Primary Physician Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Physician Phone: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Patient's Employer:

Employment Status:

Full Time  Part Time  Unemployed  Retired  Student

Emergency Contact : \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## INSURANCE INFORMATION:

Do you have insurance?  Yes  No

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_



# PULMONARY PHYSICIANS OF SOUTH FLORIDA, LLC

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

## HEALTH HISTORY

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

IF YOU HAVE A LIST OF MEDICATIONS PLEASE JUST PROVIDE A COPY

### MEDICATION LIST:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### ALLERGIES TO MEDICATIONS:

\_\_\_\_\_

TOBACCO USE: Do you or have you ever smoked?  Current  Former  Never Smoked

If so, how many cigarettes/packs per day: \_\_\_\_\_ No. of years smoking: \_\_\_\_\_

Have you thought about quitting?  YES  NO When did you stop smoking? \_\_\_\_\_

DRUG USE: Any history of illegal drug use? \_\_\_\_\_ If so, what type/s? \_\_\_\_\_

Have you received vaccinations for:  Covid  Flu  Pneumococcal

Have you fallen in the last year?  YES  NO If yes, how many times? \_\_\_\_\_

Recent travels:  Out of state  Out of country Where: \_\_\_\_\_

Animals at home:  YES  NO

If yes, which of the following:  Dogs  Cats  Birds  Other : \_\_\_\_\_

Do you have a Health Care Surrogate?  YES  NO Name: \_\_\_\_\_



# PULMONARY PHYSICIANS OF SOUTH FLORIDA, LLC

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

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

## PAST MEDICAL HISTORY

Do you now or have you ever had:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Colon Polyps             | <input type="checkbox"/> Hepatitis C         | <input type="checkbox"/> Blood Clots         |
| <input type="checkbox"/> Heartburn/ Reflux        | <input type="checkbox"/> Stomach Ulcer       | <input type="checkbox"/> Pulmonary Embolism  |
| <input type="checkbox"/> Crohn's Disease          | <input type="checkbox"/> Cancer (Type) _____ | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Ulcerative Colitis       | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Celiac Disease           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Gallstones               | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Epilepsy (seizures) |
| <input type="checkbox"/> Hemorrhoids              | <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Heart Arrhythmia    | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Hepatitis B              | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> HIV/ AIDS           |

Other Medical Conditions (please list):

---

---

Please list any SURGERIES you have had:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



# PULMONARY PHYSICIANS OF SOUTH FLORIDA, LLC

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

## EPWORTH SLEEPINESS SCALE

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

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation

0 = Would NEVER doze  
1 = SLIGHT chance of dozing  
2 = MODERATE chance of dozing  
3 = HIGH chance of dozing

SITUATION	SCALE NUMBER
SITTING AND READING	
SITTING INACTIVE IN A PUBLIC SPACE ( EXAMPLE: A THEATER OR A MEETING)	
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	
LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT	
SITTING AND TALKING TO SOMEONE	
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	
WATCHING TV	
	TOTAL SCORE



# PULMONARY PHYSICIANS

---

## OF SOUTH FLORIDA, LLC

I, the undersigned, have insurance coverage with \_\_\_\_\_

Name of Insurance Company

And assign directly to Dr. Scott Lieberman and Dr. Ali Chaudhry all medical benefits, if any, otherwise payable to me for services rendered. I understand that am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric.

\_\_\_\_\_  
Signature of insured/Guardian

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Scott Lieberman and Dr. Ali Chaudhry for any services furnished to me by that physician. I authorize 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 understand my signature request that payment be made and authorize the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency show. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of Medicare carrier

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date



# PULMONARY PHYSICIANS OF SOUTH FLORIDA, LLC

## PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM

### CONSENT TO TREATMENT

I hereby voluntarily consent to the rendering of medical treatment by the physicians and medical staff of the Pulmonary Physicians of South Florida. This may include examinations, diagnosis and/or surgical procedures, administration of injections and/or any other such medical treatment deemed necessary for the diagnosis and treatment of the patient's medical condition.

### ASSIGNMENT OF THE INSURANCE BENEFITS

I hereby authorize my insurance company to make payments on my behalf of any and all Individual, Group, Worker's Compensation, Liability or PIP benefits directly to the provider, physicians and medical staff of the Pulmonary Physicians of South Florida for medical services rendered to me.

### MEDICARE/MEDICAID ASSIGNMENT OF BENEFITS

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVII or XIX of Social Security Act is correct. I request that Medicare, Medicaid, Medigap and supplementary insurance companies make payments of authorized medical benefits to the physicians and medical staff of the Pulmonary Physicians of South Florida on my behalf.

### GUARANTY OF PAYMENT

I understand that I am financially responsible for payment to the physicians and medical staff of the Pulmonary Physicians of South Florida for any charges not covered or allowed by my insurance company and all applicable out of pocket expenses including deductibles, co-insurance and co-payments. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to the physicians and medical staff of the Pulmonary Physicians of South Florida plus any attorney fees, if applicable.

### THIRD PARTY BENEFIT COLLECTIONS

I, hereby authorize the Pulmonary Physicians of South Florida to act on my behalf as attorney in fact in (1) the collection of benefits from any responsible third-party payer through any legal means necessary and (2) in the endorsement of benefits checks made payable to me or the physicians and medical staff of the Pulmonary Physicians of South Florida.

I, \_\_\_\_\_ (PRINT NAME) ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND EACH OF THE ABOVE PROVISIONS APPEARING ON THIS FORM AND THAT BY SIGNING THIS FORM, I CONSENT TO THESE PROVISIONS INDIVIDUALLY AND COLLECTIVELY.

\_\_\_\_\_  
Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Scott Lieberman, M.D. and Ali Chaudhry M.D  
10139 NW 31<sup>st</sup> Street, Suite 103 Coral Springs, FL 33065  
P: (754)702-3247 F: (305)703-4897



# **PULMONARY PHYSICIANS**

---

## **OF SOUTH FLORIDA, LLC**

### **COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS**

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. These methods in their typical form are not confidential means of communication. If you use these methods to communicate with [PPSF, LLC], there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate with [PPSF, LLC]
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you do not want to access these communications, please talk with the office manager about ways to keep your communications safe and confidential.

[PPSF, LLC] also offers other, more secure means of communication. While it cannot be guaranteed that they will prevent 100% of confidentiality breaches, they are designed with the intention of supporting the confidentiality of clinical communications, some examples are listed below.

- Front desk pick-up at a designated time.
- Delivery via United States Postal Service.
- Secure E-Mail.

I allow [PPSF, LLC] to use unsecured email and mobile phone text messaging to transmit the following health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

---

**Patient Signature**

---

**Date**

Scott Lieberman, M.D. and Ali Chaudhry M.D  
10139 NW 31<sup>st</sup> Street, Suite 103 Coral Springs, FL 33065  
P: (754)702-3247 F: (305)703-4897



**PULMONARY PHYSICIANS**  
**OF SOUTH FLORIDA, LLC**

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

**RECORD RELEASE AUTHORITY**

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

I hereby authorize and request \_\_\_\_\_ to release complete medical  
Doctor/Facility Name  
records in your possession, concerning my illness and/or treatment on \_\_\_\_, to the physician(s)  
named above. Incorporated in this release form is my authorization for you to include any and  
all information relating to (please check as applicable)

\_\_\_\_\_ Physician Office Notes

\_\_\_\_\_ Imaging Studies ( PET, CT, Chest X-Ray, Ultrasound)

\_\_\_\_\_ Sleep Studies, PFT's, Cardiology Diagnostics Studies

\_\_\_\_\_ Labs

\_\_\_\_\_ All Medical Records

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