CHICAGO
PULMONARY SPECIALISTS
THE SCIENCE OF BREATHING

Patients Legal Name: _____ Date of Birth: ___/____/____

Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____-_____ Sex: M☐ F ☐

Parent #1 Name: _____ Date of Birth: ___/___/___

Address: _____ City/State: _____ Zip: ____ -_____

Marital Status: _____ Work Phone: (_____) _____-_____ Cell Phone: (____) _____-_____

Email: _____

Employer: _____ Occupation: _____

Parent #2 Name: _____ Date of Birth: ___/___/___

Address: _____ City/State: _____ Zip: _____

Marital Status: _____ Work Phone: (_____) _____-_____ Cell Phone: (____) _____-_____

Email: _____

Employer: _____ Occupation: _____

Who is the insurance policy holder: _____ Relationship to patient: _____

Name of Insurance carrier: _____ Policy #: _____

Emergency Contact: _____ Phone: (_____) _____-_____

Relationship to Patient: _____

Pediatrician's Name: _____ Phone: (_____) _____-_____

Address: _____ City/Sate/Zip: _____

Referring Physician: _____ Phone: (_____) _____-_____

Address: _____ City/State/Zip:_____

Authorization

- I authorize the release of medical information necessary to process my insurance claim for services rendered by "Chicago Pulmonary Specialists, S.C."
- I authorize payment of medical benefits to "Chicago Pulmonary Specialists, S.C." for medical treatment rendered to my child(ren).
- I understand that I am financially responsible for all co-pays and any charges not covered by my insurance plan.
- I have checked with my insurance company and have verified that Dr. Boas is a contracted provider with my insurance plan.
- I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Signature: _____ Date: _____

Parent or Legal Guardian

NEW PATIENT INTAKE FORM

CHICAGO PULMONARY SPECIALISTS
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Name: _____ **Date of Birth:** _____

Chief Complaint: _____

Current Medications:

Name	Dose	Frequency	Effective?

Medication Allergies:

☐ Yes, list which ones and type of reaction_____

_____

☐ No known drug allergies

Immunizations:

Up to date

Behind: list which ones

Synagis (RSV): Yes No N/A
Chicken Pox: Yes No N/A
Prevnar: Yes No N/A

Flu Vaccine: Yes No N/A
Pertussis (Whooping Cough): Yes No N/A

Birth History:

Gestation: Full term Early (<37 weeks), list # of wks _____

Delivery: Vaginal Delivery C - section, Reason _____

Birth Weight: _____ Neonatal Problems: _____

Past Medical History:

Emergency Room Visits, #, Reason: _____

Hospitalizations: _____

Other illnesses: _____

Prior Surgery: _____

Family History: (If yes, which relative)

☐Allergies_____

☐Asthma_____

☐Cystic Fibrosis_____

☐Eczema_____

☐Respiratory Problems_____

☐Other_____

Factors Known to Trigger or Worsen Symptoms

Please circle all that are applicable:

Cats	Dust	Dampness
Dogs	Fumes	Weather Changes
Other Pets	Odors	Breathing Cold Air
Indoors	Paint	Smoke
Outdoors	Exertion	Foods
Grasses	Laughing	Anxiety
Other - _____	Other - _____	Other - _____

Social/Environmental History:

Please Circle all items that are applicable:

HOME		
Lives in: House Apartment Other	If house, how old?	
How long has patient lived at present home?		
Renovated? Yes No When	Carpeting? No Yes, how old	
Hardwood Floors? Yes No	Carpet in Child's Room? Yes No	
Heat: Central Furnace Radiator Heating	Air Conditioning: Yes No	
Use of HEPA or other Filters: Yes No	Use of Humidifier: Yes No Central Room	
Pets: Dog(s): No Yes #: Type Cat(s): No Yes #: Type Other: No Yes Type:		
Rodents: Yes No	Cockroaches: Yes No	
History of Water Damage: No Yes, Repaired: Yes No History of Mold: No Yes, Cleaned: Yes No		
Exposure to anyone who smokes? No Yes, List: Indoors Outdoors		
Sleeping Quarters		
Type of Pillows: Feather Synthetic None	Pillow Cover: Yes No	
Mattress: Age: Cover: Yes No	Carpeting: Yes No	
Stuffed Animal: None Few Many	Book Cases: Open Closed None	
Pets allowed in Room: Yes No NA	Pets in Bed: Yes No NA	
Social		
Lives with: Mother Father ____Brothers ____Sisters Others (please list)		
School: None Daycare Kindergarten	Grade: Special Ed	
Type of Grades in School: A's B's C's Excellent Average Poor		
To your knowledge, does your child Smoke Yes No Don't Know Recreational Drugs Yes No Don't Know Alcohol Use Yes No Don't Know		