Palos Pulmonary & Intensive Care Consultants
Palos Sleep Center

Michael Heniff, MD Jack Beaudoin, FNP

NAME: _____ DATE: _____

HOME PHONE: _____

MEDICATION ALLERGIES

1._____
2._____
3._____
4._____
5._____

****Please list ALL of your current medications, strengths, and how you take your medication(s). (example: generic 30mg 1 time daily)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____

13303 S. Ridgeland Ave, Unit C
Palos Heights, IL 60463
Phone: 708.293.8800 Fax: 708.293.88111

Palos Pulmonary & Intensive Care Consultants
Palos Sleep Center

Michael Heniff, MD Jack Beaudoin, FNP

PATIENT INFORMATION (PLEASE PRINT)

Name _____ **Birthdate** _____
S. S. # _____-_____-_____

Address (include city, state, zip)_____

Home Phone _____ **Cell Phone** _____

Work Name & Address _____

Occupation _____ **Work Phone** _____ **Martial Status** _____

Whom may we thank for referring you? _____

Family Physician _____ **Phone#** _____

Is this work related? _____ **Date of Accident?** _____

INSURANCE INFORMATION
(Please provide **all** ins. cards to a make copy for your records)

Name of Insured _____ **Relation to Patient** _____

Birth date of Insured _____

Primary Insurance _____ **Provider Phone #**_____

Policy/ ID # _____ **Group #** _____

Insurance Address _____ **State** _____

ADDITIONAL INSURANCE? Y or N _____

Name of Insured _____ **Birth date of Insured** _____

Secondary Insurance _____ **ID #/Group** _____

AUTHORIZATION AND RELEASE
I authorize Dr.Heniff / Jack Beaudoin FNP, to perform the procedures that may be necessary for diagnosis and treatment. I authorize the release of medical information necessary to process my claims including medical history, diagnosis, prescriptions, other medical and all medical expenses related to my treatment. This authorization is valid for the duration of my claims. A copy of this authorization is also valid as well as the original. I authorize payment of medical benefits go directly to Dr.Heniff / Jack Beaudoin FNP. I accept responsibility for bill payment to include any amount not covered by my insurance. In the event that collection efforts are necessary and suit filed against me relative to any bill I incur, I agree to pay reasonable attorney's fees and costs of proceeding incurred by Dr.Heniff / Jack Beaudoin FNP.

X_____ Date:_____
SIGNATURE OF PATIENT/ REPRESENTATIVE

13303 S. Ridgeland Ave, Unit C
Palos Heights, IL 60463
Phone: 708.293.8800 Fax: 708.293.88111

Palos Pulmonary & Intensive Care Consultants
Palos Sleep Center

Michael Heniff, MD Jack Beaudoin, FNP

NAME: _____ DATE: _____

BACKGROUND (circle answer)

1. **Non-Smoker**
2. **Ex-Smoker When Stopped _____**
3. **Current Smoker**

FOR CURRENT AND EX-SMOKERS

1. **How many years have you smoked? _____**
2. **Approximately how many packs per day did you smoke? _____**

ALCOHOL CONSUMPTION (circle answer)

1. **NEVER**
2. **RARELY**
3. **A COUPLE OF DRINKS WEEKLY**
4. **MORE THAN 2 DRINKS DAILY**
5. **A COUPLE DRINKS DAILY**
6. **OTHER _____**

WHEN WAS YOUR LAST FLU SHOT? _____

WHEN WAS YOUR LAST TETANUS SHOT? _____

RACE: ☐ **White** ☐ **African American** ☐ **American Indian** ☐ **Asian** ☐ **Native Hawiian or Other Pacific Islander**

ETHNICITY: ☐ **Non-Hispanic or Latino** ☐ **Hispanic or Latino**

DO YOU NOW HAVE OR HAVE YOU EVER HAD: (circle answer)

YES	NO	
0	**0**	**Rejected from military or refused employment for health reasons**
0	**0**	**Been on disability or pension**
0	**0**	**Treatment for alcohol or substance abuse**
0	**0**	**Hospitalized for illness or injury**
0	**0**	**Fractured Bone**
0	**0**	**Head or nerve injury**
0	**0**	**Work related injury**
0	**0**	**Back sprain or other back injury or pain**
0	**0**	**Hernia**
0	**0**	**Cancer or other malignant tumor**
0	**0**	**Arthritis or joint problem**
0	**0**	**Surgical operation**
0	**0**	**Asthma, bronchitis or any other respiratory illness**
0	**0**	**Skin rash or problem**
0	**0**	**Allergy to environmental agents or occupational product**

13303 S. Ridgeland Ave, Unit C
Palos Heights, IL 60463
Phone: 708.293.8800 Fax: 708.293.88111

Palos Pulmonary & Intensive Care Consultants
Palos Sleep Center

Michael Heniff, MD Jack Beaudoin, FNP

NAME: _____ DATE: _____

0	**0**	**Ear disease or Hearing problem**
0	**0**	**Color vision defects or tunnel vision**
0	**0**	**Wear contacts or glasses (circle answer)**
0	**0**	**Heart disease or high blood pressure**
0	**0**	**Stomach or intestinal problems**
0	**0**	**Kidney, bladder or reproductive organ problems**
0	**0**	**Diabetes, thyroid or other endocrine problems**
0	**0**	**Frequent headaches or history of seizures or black-outs**
0	**0**	**Dizziness or balance problem**
0	**0**	**Menstrual problems (female only)**
0	**0**	**Trouble sleeping**

HAVE YOU BEEN EXPOSED TO THE FOLLOWING FOR MORE THAN A BRIEF PERIOD OF TIME? (CIRCLE ALL THAT APPLY)

1. ASBESTOS	**10. RADIATION**
2. CHEMICAL FUMES	**11. HIGH INTENSITY NOISE**
3. SOLVENTS / DEGREASING FLUIDS	**12. PLASTIC FUMES OR PRODUCTION PRODUCTS**
4. DRY CLEANING FLUIDS	**13. SANDBLASTING / FOUNDRY WORK**
5. WELDING OR SOLDER FUMES / FLUXES	**14. PHOTOGRAPHIC OR PRINTING CHEMICALS**
6. AGRICULTURAL SPRAYS	**15. MICROWAVE RADIATON**
7. PESTICIDES	**16. OFFICE MACHINERY THAT PRODUCES IRRITATING FUMES OR VAPORS**
8. TARS OR PETROLEUM PRODUCTS	**17. SMOKE INHALATION FROM FIRES**
9. PAINT FUMES / GLUE FUMES	**18. OTHER FUMES / VAPORS / DUSTS/ ETC.**

I ATTEST THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ **DATE** _____

13303 S. Ridgeland Ave, Unit C
Palos Heights, IL 60463
Phone: 708.293.8800 Fax: 708.293.88111

Palos Pulmonary & Intensive Care Consultants
Palos Sleep Center

Michael Heniff, MD Jack Beaudoin, FNP

TO ALL NEW PATIENTS:

The evaluation you will undergo is considered a specialist's opinion on the probable cause of your complaint and the most likely successful therapy for your problem. The therapy usually can be completed by and followed through by your family physician. This is usually followed with occasional re-evaluation by our staff as necessary. This normally does not replace the role of your private family physician. Please let us know who your family physician is so that they can be informed of your exam findings.

Patient Signature _____ Date _____

Print Name: _____

13303 S. Ridgeland Ave, Unit C
Palos Heights, IL 60463
Phone: 708.293.8800 Fax: 708.293.88111

Palos Pulmonary & Intensive Care Consultants
Palos Sleep Center
Michael Heniff, MD Jack Beaudoin, FNP

NOTICE

1. TEST RESULTS: (ie: PET scans, CT scans, ECHOs, Biopsy) will no longer be given via the telephone. A follow-up appointment is required. Please schedule your next appointment before leaving the office or when you receive a date for your test.

2. **PHARMACY REFILLS:** If you require a refill, have your pharmacy send us a refill request via FAX. We will no longer call your pharmacy for a refill.

3. **MAIL ORDER PRESCRIPTIONS (90 DAY SUPPLY):** require an office visit. Make sure to obtain your prescriptions at your office visit.

4. **INSURANCE, TELEPHONE, ADDRESS:** It is your responsibility to make sure we have your correct insurance/contact information.

I hereby understand the imposed rules and regulation of this medical facility. I agree to comply with the above mentioned regulations.

SIGNED:_____ DATE: _____

PRINT: _____

13303 S. Ridgeland Ave, Unit C
Palos Heights, IL 60463
Phone: 708.293.8800 Fax: 708.293.88111

Palos Pulmonary & Intensive Care Consultants
Palos Sleep Center
Michael Heniff, MD Jack Beaudoin, FNP

HIPAA CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices before signing this consent. A more complete description of this clinic's privacy policy is available upon my request.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Patient Signature _____ Date _____

Print Name _____

Patient Representative _____ Relationship

Witness _____ Date _____

13303 S. Ridgeland Ave, Unit C
Palos Heights, IL 60463
Phone: 708.293.8800 Fax: 708.293.88111