Last Name:	First Name:		Middle Initial:	
Mailing Address:	Apt #:	City:	State:	Zip Code:
Home Phone #:	Social Security #:	Date of Birth: Mo./Day/Year	Sex: ❑ M ❑ F	
Alternate Phone #:	Cell Phone:	Email:		
Name of Employer:	Business Phone:	Date of Injury: Mo./Day/Year	Claim #:	
Street Address:	City:	State:	Zip Code:	
Medicare or Medicare Replacement plan patients only. Are you currently receiving skilled Nursing or Hospice Care? If yes, please provide the name of the Nursing Facility or Provider below			❑ Yes ❑ No	

RESPONSIBLE PARTY The Responsible Party is the person, company or organization ultimately responsible for payment of services. If the Patient and the Guarantor are the same, write "See Patient" in the box of Last Name

Last Name:	First Name:	Middle Initial:	Relationship to Patient:
Street Address:	City:	State:	Zip Code:
Home Phone #:	Social Security #:	Date of Birth: Mo./Day/Year	Sex: ❑ M ❑ F

Your medical provider is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients. Thank you for your assistance.

1. What is your smoking status?

❑ Current everyday smoker
Do you have a history of 30 pack-years? ❑Yes ❑No
(1 pack year = smoking 1 pack daily for 1 year)
❑ Current some day smoker
❑ Former smoker
Have you quit within the last 15 years? ❑Yes ❑No
❑ Never Smoker
❑ Smoker, current status unkown
❑ Unknown in ever smoked

2. Preferred Language

☐ English
☐ Spanish
☐ Other: _____

3. Are you between the ages of 55 and 77? ❑Yes ❑No

4. Do you have any signs or symptoms of lung cancer? ❑Yes ❑No

5. Do you have any allergies? Please List.

_____
_____
_____

Clear Form