William Tony McKenzie, MD
ABIM Board Certified in Pulmonary,
Sleep Medicine & Internal Medicine
www.thelungandsleepcenter.com

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PAYMENT IS DUE AT TIME OF SERVICE, THIS INCLUDES ALL COPAYS, DEDUCTIBLES AND BALANCES

Please Print Legible

Today's Date______________________ Primary Doctor_________________________

Last Name_______________________First_____________________Middle___________

Date of Birth_______________ Age________ Sex assigned at birth (male\ female)________

Mailing Address____

City_________________________State__________Zip Code___________-___________

Primary Phone ___________________________Cell Phone_________________________

Appointment Reminder Preference (Circle) Phone and Email OR Text Only

Social Security_________________________Email______________________________

Race___________ Ethnicity: Hispanic Non Hispanic Spoken Language________________

Marital Status: Single Married Separated Divorced Widowed

Emergency Contact Name____________________________ Phone____________________

Employer Name and Address____

Person Responsible for Bill Date of Birth Address (if different) Phone

___________________________ __________ ____________________ __________

Primary Insurance Subscribers Name & Date of Birth Subscribers Social Security

_________________ _____________________________ ___________________________

Policy Group Subscribers Relationship to Patient

_________________ _________________ ____

Secondary Insurance Subscribers Name & Date of Birth Subscribers Social Security

_________________ _________________________________ _______________________

Policy Group Subscribers Relationship to Patient

________________ _________________ ____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for any balance. I also authorize The Lung and Sleep Center or insurance company to release any information required to process my claims.

*****THERE IS A $25.00 CHARGE FOR ALL MISSED APPOINTMENTS IF NOT CHANGED WITHIN 24 HRS** INITIAL_________***

Patient/Guardian
Signature____Date__________________

Name____ Date of Birth ________________

Are you currently under the care of a physician? oYes oNo

Cardiologist: ____________________________
GI Physician: ____________________________
Neurologist: ____________________________
Endocrinologist: ____________________________
Primary Physician: ____________________________
ENT: ____________________________
Oncologist/Hematologist: ____________________________
Ophthalmologist: ____________________________
Other: ____________________________

Personal and Social History

Do you use tobacco in any form? oYes oNo
If Yes, what kind: o Cigarettes o Cigars o Chewing Tobacco o Others (please list) ________________
Have long have/had you smoked? ___________ On Average, how many packs per day? ___________
Have you quit? oYes oNo If Yes, When? ___________
Have you ever had significantly exposed to 2nd hand smoke? oYes oNo If Yes, As a Child/Adult/Both
Have you had any Chemical Exposures? oYes oNo If Yes, What Kind?___________ When: / /

Health Maintenance

HIV Test (date) __/__/__ Result (circle one) NEG/POS Tuberculosis (date) __/__/__ Result (Circle One) NEG/POS
Immunizations (last year received)
Tetanus __/__/__ Covid __/__/__ RSV __/__/__ Pneumonia __/__/__ Flu Shot __/__/__

Do you have, or have you had any of the following medical conditions?

☐ **Anemia**	☐ **Diabetes**	☐ **Heart Murmur**	☐ **Mental Disorders**	☐ **Rheumatism**
☐ **Arthritis**	☐ **Dizziness**	☐ **Hepatitis**	☐ **Nervous Disorders**	☐ **Sinus Problems**
☐ **Artificial Joints**	☐ **Epilepsy**	☐ **High Blood Pressure**	☐ **Pacemaker**	☐ **Sleep Apnea**
☐ **Asthma**	☐ **Excessive Bleeding**	☐ **HIV**	☐ **Pregnancy**	☐ **Stroke**
☐ **Blood Disease**	☐ **Fainting**	☐ **Jaundice**	☐ **Radiation Treatment**	☐ **Tuberculosis**
☐ **Cancer**	☐ **Head Injuries**	☐ **Kidney Disease**	☐ **Respiratory Problems**	☐ **Tremors**
☐ **COPD**	☐ **Heart Disease**	☐ **Liver Disease**	☐ **Rheumatic Fever**	☐ **Other**

If you answered "Other" please specify/explain: ____________________________________

Please list any surgeries you have had and date completed:

____
____
____
____
____
____
____
____
____

Patient's Signature: ________________________________ **Date:** ____/____/______

Name____ Date of Birth ___________________

Review of Systems

Have you had any of the following within the six months?
Please check the appropriate circle next to each heading.

SYSTEM	YES	NO
Constitutional		
Unexplained Weight Loss	O	O
Unexplained Weight Gain	O	O
Fever	O	O
Chills	O	O
Nausea	O	O
Vomiting	O	O
Fatigue	O	O
Eyes		
Blurred Vision	O	O
Loss of Vision	O	O
Glasses	O	O
Contacts	O	O
Red Eye	O	O
Spots	O	O
ENMT		
Hearing Loss	O	O
Ringing in Ears	O	O
Nosebleed	O	O
Sinus Drainage	O	O
Change in Voice	O	O
Hoarseness	O	O
Mouth Sores	O	O
Bleeding Gums	O	O
Dentures	O	O
Teeth Grinding (Bruxism)	O	O
Respiratory		
Cough	O	O
Cough up Blood	O	O
Congestion	O	O
Pain in Chest	O	O
Wheezing	O	O
Shortness of Breath w/ Sitting	O	O
Shortness of Breath w/Exertion	O	O

SYSTEM	YES	NO
Cardiovascular		
Chest Pain	O	O
Skipping/Irregular Beats	O	O
Leg Pain while Walking	O	O
Leg Swelling	O	O
Shortness of Breath at Night	O	O
Problems with Exercise	O	O
Skin		
Skin Lesions	O	O
Skin Itching	O	O
Rashes	O	O
Dry Skin	O	O
Gastrointestinal		
Blood in Stool	O	O
Change in Movement	O	O
Black Tarry Stool	O	O
Constipation	O	O
Diarrhea	O	O
Heartburn/Reflux	O	O
Difficulty Swallowing	O	O
Hemorrhoids	O	O
Genitourinary		
Difficulty Urinating	O	O
Blood in Urine	O	O
Hernias	O	O
Incontinence	O	O
Urination at Night	O	O
Urinary Urgency	O	O
Erectile Dysfunction	O	O
STD	O	O
Muscular Skeletal		
Joint Pain	O	O
Stiffness	O	O
Red/Swollen Joints	O	O
Gout	O	O
Neck Pain	O	O
Back Pain	O	O

SYSTEM	YES	NO
Hematology/Oncology		
Anemia	O	O
Bruise Easily	O	O
Swollen Lymph Nodes	O	O
Cancer(s)	O	O
Psychiatric		
Depression/Sadness	O	O
Anxiety	O	O
Problems with Concentration	O	O
Problems with Memory	O	O
Neurology		
Dizziness	O	O
Headaches	O	O
Numbness	O	O
Tremors	O	O
Imbalance	O	O
Change in Memory	O	O
Weakness	O	O
Seizures	O	O
Endocrine		
Problems w/Heat	O	O
Problems w/Cold	O	O
Excessive Thirst	O	O
Hair Loss	O	O
Swelling in the Neck	O	O
Sleep Medicine		
Insomnia	O	O
Shiftwork	O	O
Snoring	O	O
Excessive Daytime Sleepiness	O	O
Fatigue	O	O
Non-Refreshing Sleep	O	O
Non-Restorative Sleep	O	O
Frequent Arousals from Sleep	O	O
Disturbed/Restless Sleep	O	O
Act out Dreams	O	O
Violent Dreams	O	O
Seizures at Night	O	O
Restless Legs	O	O

FAMILY HISTORY

(MARK THE BOX IN FRONT FOR THOSE THAT APPLY)

	Alzheimer's Disease		Alpha 1 Deficiency		Diabetes		Thyroid Disease
	Cancer		High Blood Pressure		High Cholesterol		Sickle Cell Disease
	Heart Disease		Lung Disease		Obesity		Anemia
	Stroke		Substance Abuse		Glaucoma		Asthma
	Macular Degeneration		Depression/Suicide		Narcolepsy		Other

WILLIAM T. MCKENZIE MD

NAME: ______________________________ DOB: __________________________

MEDICATION ALLERGIES: ____

____

____

LOCAL PHARMACY: ____________________ MAILORDER PHARMACY: __________________

(PHARMACY LIMITED TO ONE LOCAL AND ONE MAILORDER)

PLEASE PRINT MEDICATIONS AND DIRECTIONS BELOW

MEDICATION NAME *EX: ASPRIN*	**DOSE /STRENGTH** *EX: 81MG*	**HOW OFTEN** *EX: 1 TABLET ONCE DAILY*

PATIENT NAME:__________________________________ DOB:________________________

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ________________________, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

A basis for planning my care and treatment; a means of communication among the many health professionals who contribute to my care; a source of information for applying my diagnosis and surgical information to my bill; a means by which a third-party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I authorize the release of any medical information to my insurance carrier which is necessary to process my insurance claims. I also authorize my insurance benefits to be paid directly to my physician, realizing I am responsible to pay for non-covered services.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing; except to the extent that the organization has already taken in reliance thereon.

I request the following restrictions to the use and disclosure of any health information:

____

____

I authorize the release of my laboratory results or tests, scheduling or changing appointments and reminders of upcoming appointments, to verify if I am ready to be picked up from my visit and/or to pick up prescriptions, to speak to the Finance Department in regard to my account/billing and any other special requests to:

(1)______________________________ Relationship __________________________

(2)______________________________ Relationship __________________________

(3)______________________________ Relationship __________________________

I authorize The Lung and Sleep Center to send reminder notices of upcoming appointments to me or to leave messages on my telephone answering machine.

Yes _______ No _______

I fully understand and accept/decline the terms of this consent.

____

Signature DOB Date

1397 Jenks Ave #1
Panama City, FL 32401
Phone: (850) 522-LUNG(5864)
Fax: (850) 522-5863
William Tony McKenzie, M.D.

AUTHORIZATION TO *REQUEST* MEDICAL RECORDS

This form is used to have your records sent to The Lung and Sleep Center

PATIENT NAME: ____

DATE OF BIRTH: ____________________

I, ____________________ HEREBY AUTHORIZE THE LUNG AND SLEEP CENTER AND/OR ITS AGENTS:

________ TO REQUEST INFORMATION REGARDING MY MEDICAL CARE AND /OR TREATMENT

____

____

____

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN.

______________________________ ____________

PATIENT SIGNATURE (PARENT, GUARDIAN, CARETAKER) DATE

____

RELATIONSHIP IF OTHER THAN PATIENT

______________________________ ____________

WITNESS SIGNATURE DATE

Watermark Medical ARES Questionnaire ©

PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX All Fields Required-unless otherwise specified

Last Name | First Name | Middle Initial | Gender: Male / Female

Date of Birth Month Day Year | **Weight** Pounds | **Height** Feet Inches | **Neck Size** Inches

I.D. Number (optional)

Tally ARES Risk Points

Neck Size +2 Male ≥16.5 +2 Female ≥15

Score

COMPLETELY FILL IN ONE SQUARE FOR EACH QUESTION - ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

Condition	Yes	No	Condition	Yes	No
High blood pressure	Yes	No	Stroke	Yes	No
Heart disease	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Sleep Apnea	Yes	No
Lung disease	Yes	No	Nasal oxygen use	Yes	No
Insomnia	Yes	No	Restless legs syndrome	Yes	No
Narcolepsy	Yes	No	Morning Headaches	Yes	No
Sleep Medication	Yes	No	Pain Medication e.g. vicodin, oxycontin	Yes	No

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 tomark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze 1 = slight chance of dozing
2 = moderate chance of dozing 3 = high chance of dozing

Situation	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (theater, meeting, etc)				
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				

Epworth Score Total the values from all 8 questions. If 11 or less Score = 0 If 12 or more Score = 2

Score

Frequency (Check one for each question): Never **+0**, Rarely **+1** times/wk, Sometimes **+2** times/wk, Frequently **+3** times/wk, Almost Always **+4** times/wk.

On average in the past month, how often have you snored or been told that you snored?

Never +0 | Rarely +1 | Sometimes +2 | Frequently +3 | Almost always +4

Do you wake up choking or gasping?

Never +0 | Rarely +1 | Sometimes +2 | Frequently +3 | Almost always +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never +0 | Rarely +1 | Sometimes +2 | Frequently +3 | Almost always +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never | Rarely | Sometimes | Frequently | Almost always

Total points for the first three responses

I have personally completed this questionnaire.
Signature | Date | Phone Number

Total all 4 boxes from the right side
If points total =3 or lower (no risk)
4 or 5 (low risk), 6 to 10
(high) and 11 or more (very high risk)

Point Total

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