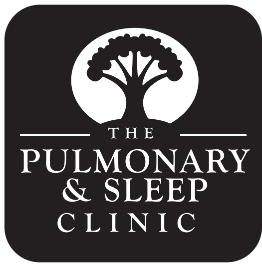


Cynthia Spilker, MD, FCCP
Sonica Saini, MD, MPH
Patrick Perkins, MD, FCCP
Ashley Ferraro, DO, FCCP

2521 Glenn Hendren Drive, Suite 402 Liberty, Missouri 64068
9151 NE 81st Terrace, Suite 200 Kansas City, Missouri 64158 **P** 816-781-8445 **www.libertyhospital.org**

Patient Name: ____________________

Today's Date: ____________________ Date of Birth: ____________________

Referring Dr: ____________________ Primary Dr: ____________________

Reason for Visit Today: ____________________

Please check any symptoms YOU have had in the last three months?

Constitutional:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise (no energy)
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:

HEENT:
- ☐ Ear drainage
- ☐ Other:
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Other: ____________
- ☐ Sore Throat
- ☐ Visual changes
- ☐ Other: ____________
- ☐ Chronic cough
- ☐ Cough
- ☐ TB Exposure
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other: ____________

Cardiovascular:
- ☐ Chest pain
- ☐ Leg pain
- ☐ Edema
- ☐ Palpitations
- ☐ Other: ____________

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Change in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heart burn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Other: ____________

Genitourinary:
- ☐ Dysuria (burning)
- ☐ Hematuria
- ☐ (blood in urine)
- ☐ Frequency
- ☐ Incontinence
- ☐ Urinary retention
- ☐ Other: ____________

Skin:
- ☐ Itching
- ☐ Rash
- ☐ Other: ____________

Neurological:
- ☐ Dizziness
- ☐ Numbness
- ☐ Weakness: ____________
- ☐ Gait disturbance (problems walking)
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors
- ☐ Other: ____________

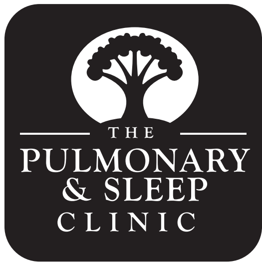
Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other: ____________

Metabolic/Endocrine:
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- Other ____________

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Other: ____________

Hematology:
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Enlarged Lymph Nodes
- ☐ Other: ____________

Immunologic:
- ☐ Contact allergy
- ☐ Environmental allergy
- ☐ Food allergy
- ☐ Seasonal allergy
- ☐ Other: ____________



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Patient Name: ______________________________

Today's Date:____________________ Date of Birth: ______________________

Medical History:

Please check any of the following problems with which YOU have ever been diagnosed.
Please put the approximate year you were diagnosed with the problem.

Medical History:

Condition	Year Diagnosed
☐ Allergies	________
☐ Anemia	________
☐ Angina	________
☐ Anxiety	________
☐ Arthritis	________
☐ Asthma	________
☐ Atrial fibrillation	________
☐ Blood clots	________
☐ Cancer (Type)	________
☐ Cardiac Arrhythmia	________
☐ COPD	________
☐ Coronary Artery Disease	________
☐ Depression	________
☐ Diabetes	________
☐ Elevated Lipids	________
☐ Gallbladder Disease	________
☐ GERD (Heartburn/Reflux)	________
☐ Headache, migraine	________
☐ Heart Disease	________
☐ Heart Valve Disorder	________
☐ Hepatitis/Liver Disease	________
☐ Hypertension	________
☐ Irritable Bowel Disease	________
☐ Myocardial Infarction	________
☐ Osteoporosis	________
☐ Renal Disease	________
☐ Seizure Disorder	________
☐ Stroke	________
☐ Thyroid Disease	________
☐ Other (specify below)	

____

Pulmonary (Lung) Problems:

Condition	Year Diagnosed
☐ Alpha 1 Antitrypsin Deficiency	________
☐ Asthma	________
☐ Bronchiectasis	________
☐ Chronic Bronchitis	________
☐ COPD	________
☐ Emphysema	________
☐ Pleural Effusion (fluid around lung)	________
☐ Pneumonia	________
☐ Pneumothorax (collapsed lung)	________
☐ Positive TB test	________
☐ Pulmonary Emboli (blood clots)	________
☐ Pulmonary Fibrosis	________
☐ Pulmonary Hypertension	________
☐ Restless Legs Syndrome	________
☐ Sleep Apnea	________
☐ Tuberculosis	________
☐ Other (specify below)	________

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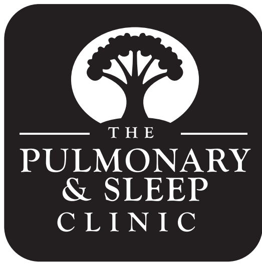

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Today's Date:________________ Date of Birth: ________________

Medical History:
Please check any of the following problems with which YOU have ever been diagnosed.
Please put the approximate year you were diagnosed with the problem.

Surgical History:

Procedure	Year Diagnosed	Procedure	Year Diagnosed
☐ Angioplasty	______	☐ D & C	______
☐ Appendectomy	______	☐ Gastric Bypass	______
☐ Arthroscopy	______	☐ Hernia Repair	______
☐ Back Surgery	______	☐ Hip Replacement	______
☐ Bilateral tubal ligation	______	☐ Hysterectomy	______
☐ Blood transfusion	______	☐ Knee Replacement	______
☐ Breast augmentation	______	☐ LASIK	______
☐ CABG	______	☐ Mastectomy	______
☐ Cardiac Pacemaker	______	☐ Myomectomy	______
☐ Carpal Tunnel Release	______	☐ ORIF (Surgery to repair a broken bone)	______
☐ Cataract Extraction	______	☐ Thyroidectomy	______
☐ Cholecystectomy	______	☐ Tonsillectomy	______
☐ Colectomy	______	☐ Other (specify below)	______
☐ Colostomy	______	____________	

Lung Surgeries/Procedures:

Procedure	Year Diagnosed	Procedure	Year Diagnosed
☐ Bronchoscopy	______	☐ Pneumonectomy (removed whole lung)	______
☐ Chest Tube	______	☐ Thoracentesis (drain fluid)	______
☐ Lobectomy (removed part of lung)	______	☐ VATS (scope surgery for fluid)	______
☐ Lung Biopsy	______	☐ Other (specify below)	______
		____________	

Write in any additional health problems or surgeries; use back of page if needed.

____
____
____
____
____
____

THE PULMONARY & SLEEP CLINIC

Cynthia Spilker, MD, FCCP
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Patient Name: ____

Today's Date:________________________ Date of Birth: ______________________________

Allergies:

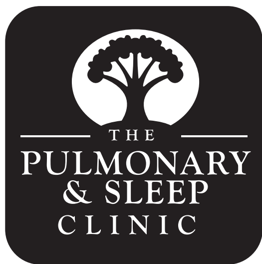
Drug	Reaction	Drug	Reaction

Name of Pharmacy___________________________________

Name of Mail Order Pharmacy__________________________

Medications: Please fill in your current medications and any you have stopped in the last three (3) months; please request second page if necessary.

Medication	Dosage	Directions	Start Date	Stop Date	Dr. Who Prescribed	Why you take medication



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Patient Name: ____

Today's Date:________________________ Date of Birth: ______________________________________

Social History:

Occupation: __________________________

Do you currently use Tobacco? Yes___ No___
Have you previously used tobacco? Yes___ No____
If Prior, Date Quit: ____________

Average Packs per Day? ______ Number of Years Smoked? _______
Check if you use Chewing Tobacco ____ Vaping ___ E-Cigarettes ____ Marijuana ________
Other Drugs: _____

Do you consume Alcohol? Yes___ No___ Number of Alcoholic Drinks per Day? ________

Do you have any birds in your home? Yes___ No____
Any other pets in your home? Yes___ No ___ If so, what kind? ____________

Family History:

Do you have any FAMILY HISTORY of the following conditions:
DO NOT INCLUDE YOURSELF OR SPOUSE, DO NOT INCLUDE RELATIVES BY MARRIAGE ONLY.

Condition:	Family Member(s) Affected	Age of Onset	Cause of Death
ADD/ADHD			
Alcoholism			
Allergies			
Alzheimer's			
Arthritis			
Asthma			
Blood Disorder			
Cancer	Type:		
Cardiac (heart)			
Diseases			
Coronary Artery Disease			
Depression			
Developmental Delay			
Diabetes			
Eczema			
Other (specify below):			

Condition:	Family Member(s) Affected	Age of Onset	Cause of Death
Elevated Lipids			
Genetic Disease			
Hearing Loss			
Hypertension			
Irritable Bowel Syndrome			
Learning Disability			
Mental Illness			
Migraines			
Obesity			
Osteoporosis			
Peripheral Vascular Disease			
Renal (kidney) Disease			
Seizures			
Stroke			
Thyroid Disease			

Add any additional family health history below; use back of page if needed.

Specialty Clinics

Advanced Spine & Brain Center
Liberty Cardiothoracic Surgeons
Liberty Cardiovascular Specialists
MU Orthopaedics
The Ear, Nose & Throat Clinic
The Pulmonary & Sleep Clinic
The Surgeons Clinic

Permission to Disclose Information to Those Involved in My Care

I hereby allow The Primary Care and Specialty Clinics of Liberty Hospital to disclose the following information. (Check all that apply) This form does not authorize releasing copies of my medical records.

☐ Appointment times and dates
☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
☐ Tests that have been performed
☐ Test results
☐ Billing/payment information

Other health information (describe)____

To the following people who are involved with my healthcare and/or payment information:
(Check all that apply and list names and telephone numbers)

☐ Spouse____ Phone:__________________
☐ Friend____ Phone:__________________
☐ Child(ren)_______________________________________ Phone:__________________
☐ Other____ Phone:__________________

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail? (Check all that apply)

☐ No, DO NOT leave messages
☐ Yes, at home
☐ Yes, at cell
☐ Yes, at work

Home Phone:__________________
Cell Phone:____________________
Work Phone:___________________

I understand that in certain situations The Primary Care and Specialty Clinics of Liberty Hospital could speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permssion at any time.

Patient Name (please print):______________________________________ Date of birth:______________

Patient/Guardian Signature:_______________________________________Date:___________________

If patient is a minor, please complete the following information:

Mother's name/contact number:____

Father's name/contact number:____

Advanced Spine & Brain Center
Liberty Cardiothoracic Surgeons
Liberty Cardiovascular Specialists
MU Orthopaedics
The Ear, Nose & Throat Clinic
The Pulmonary & Sleep Clinic
The Surgeons Clinic

Notice of Privacy Practices and Patient Rights

By signing this document, I acknowledge that I have received a copy of The Primary Care and Specialty Clinics of Liberty Hospital Notice of Privacy Practices and Patient Rights. Copies are available at your provider's office or view a PDF at www.libertyhospital.org/privacy.

Patient Signature: ________________________________ Date__________ Time__________
Date of Birth:________________

Patient Representative/Relationship Signature:

____ Date__________ Time__________

Witness: ____ Date__________ Time__________

For Specialty Clinics of Liberty Hospital use only:

If the patient's signature was not obtained, please describe reason why below:

☐ Patient refused to sign Acknowledgement.

☐ Patient unable to sign Acknowledgement due to emergent condition.

Other: Describe below:

____

____

____

The Primary Care and Specialty Clinics of Liberty Hospital is required by law to make a good faith effort to obtain a written acknowledgement from the patient receiving treatment regarding receipt of our Notice of Privacy Practices. A patient's failure or refusal of this acknowledgement should not interfere with delivery of treatment. 45 CFR 164.520

The Primary Care and Specialty Clinics of Liberty Hospital is required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines

Advanced Spine & Brain Center
Liberty Cardiothoracic Surgeons
Liberty Cardiovascular Specialists
MU Orthopaedics
The Ear, Nose & Throat Clinic
The Pulmonary & Sleep Clinic
The Surgeons Clinic

Financial Policy

Methods of Contact: I agree, in order to service my account or to collect any amounts I may owe, that Liberty Hospital or its Business Associates may contact me by telephone, at any telephone number associated with my account, which could result in charges. I agree to contact by text messages or e-mails (using any e-mail address provided). Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Thank you for choosing us as your health care providers. We are committed to providing quality medical care and your successful treatment. Please understand that payment of your bill is considered to be your responsibility as part of your treatment. The following is our financial policy, which we request that you read and sign prior to any treatment.

1. Co-pays and balances are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we receive a response from them. As a courtesy, we accept cash, checks, Visa, Discover and Master Card.
2. If you have an HMO or PPO insurance with a designated Primary Care Physician, please make sure you have selected a physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.
3. Any balance is your responsibility after insurance processes your claim. Please be aware that some, and perhaps all, of the services provided may not be covered services, and not considered reasonable and necessary under the Medicare program and/or other medical insurance. In this case, the balance is your responsibility. If you have a question about your benefits, please call your insurance company prior to your office visit and check your benefits.
4. If your visit is due to a motor vehicle accident, you may choose to file your health or auto insurance. You may also choose to be self-pay, and as such would be required to pay for the visit in full at the time of service.
5. Responsibility for payment for services rendered to the child/children of divorced or separated parents rests with the parent who seeks treatment. Any court-ordered judgment must be between the individuals involved, without including our facility or providers.
6. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full.
7. All returned checks must be paid with cash or money order within 5 working days or they will be turned over to the prosecuting attorney's office. A fee of $25 will be charged on all returned checks.
8. All deductibles and copayments for Obstetric (OB) services must be paid in full by the 7th month of pregnancy with regular payments due each month by cash, check or credit card.

Our clinics are committed to providing the best treatment for our patients. Our charges are what are usual and customary for our area. It is our hope that you will find this information helpful.

PATIENT/GUARDIAN'S SIGNATURE	PRINT PATIENT'S NAME & BIRTH DATE	DATE

Signature on File

I authorize use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to the clinic I attend. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for all charges whether or not covered by my insurance.

PATIENT/GUARDIAN'S SIGNATURE	DATE