BREATHEWELL PULMONARY CLINIC

3450 E Fletcher Ave STE 260, Tampa FL 33613
Phone: 813-419-3108 Fax: 813-482-0542

Patient Information

Full Name: _____

DOB: _____ SSN: _____Gender: ☐ M ☐ F

Address: _____

Cell: _____ Work: _____ Home: _____

Email Address: _____ Pharmacy Phone: _____

Emergency Contact: _____ Phone: _____

Race: _____ Ethnicity: _____ Language: _____

Physician/ Insurance Information

Physician Name: _____ Phone Number: _____

Primary Insurance: _____ Policy: _____ Group Number: _____

Secondary Insurance: _____ Policy: _____ Group Number: _____

Medical History

1. Do you have any known allergies? ☐ No ☐ Yes (please list) _____

2. Do you currently smoke? ☐ No ☐ Yes ☐ Former Smoker (Year Quit: _____)

3. Do you use oxygen therapy? ☐ No ☐ Yes, at home ☐ Yes, continuous

4. Have you ever been diagnosed with any of the following conditions? (Check all that apply)

☐ Asthma ☐ COPD ☐ Sleep Apnea ☐ Pulmonary Fibrosis ☐ Tuberculosis ☐ Emphysema ☐ Lung Cancer ☐ Pneumonia ☐ Bronchitis ☐ Other: _____

5. Do you have any other chronic conditions? ☐ No ☐ Yes, please specify: _____

1. Consent for Medical Treatment

I, the undersigned, voluntarily consent to the medical treatment and diagnostic procedures that are deemed necessary by the healthcare providers at BreatheWell Pulmonary Clinic. I understand that treatment may include physical exams, laboratory tests, imaging, and other diagnostic or therapeutic procedures as necessary for my care.

2. Financial Responsibility & Insurance

I understand that I am responsible for all charges incurred during my treatment. If my insurance does not cover services, I agree to pay any remaining balance. I authorize BreatheWell Pulmonary Clinic to release any medical information necessary for billing purposes to my insurance provider.

3. Release of Medical Information

I authorize the release of my medical information to my referring physician, primary care provider, or other specialists involved in my care. I also understand that my medical records will be kept confidential and will not be disclosed without my written consent, except as required by law.

Authorization for Family Member Access (Optional)

I authorize Breathewell Pulmonary Clinic to release my medical information to the following individual:

Name: _____
Relationship to Patient: _____

This authorization allows the named individual to discuss my treatment, appointments, and billing information with Breathewell Pulmonary Clinic. I understand that I may revoke this authorization at any time in writing.

4. Telehealth Consent (if applicable)

I understand that telehealth services may be offered as part of my care. I consent to receive healthcare services via telecommunication and understand the risks, benefits, and limitations of telehealth.

5. Acknowledgment & Signature

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined in this consent form.

Patient Signature: _____Date: _____

Guardian/Representative (if applicable): _____

Relationship to Patient: _____