Dear Patient:

Welcome to Annapolis Thoracic Surgery Associates, a professional physician’s practice of the Anne Arundel Medical Center’s Geaton and JoAnn DeCesaris Cancer Institute, Dr. Stephen Cattaneo and Dr. Avedis Meneshian. We are pleased that you have chosen us as partners in your care. This letter contains information that we hope will enhance the experience of your upcoming visit. Please read this letter and the enclosed information carefully. We will be happy to answer any questions you may have prior to your visit by calling the number listed below from 8:00 a.m. through 4:00 p.m., Monday through Friday.

We look forward to meeting you at your scheduled appointment on ____________________________ at ____________ a.m. / p.m.

The Wayson Pavilion
Anne Arundel Medical Center Campus
2003 Medical Parkway, Suite 301
Annapolis, Maryland 21401
Phone 443-481-3300 Fax 443-481-3315

Please arrive at least 15 minutes prior to your appointment time. Directions to our facility are included in this packet along with parking instructions. Parking is free in the adjacent garage (Garage B / Wayson). There is also a valet service at the front of the building for a fee of $6.

To facilitate this visit we ask that you complete the enclosed forms prior to your arrival in our office: the New Patient History Form and the Physicians List. Please fill these out as carefully and completely as you can. We are especially interested in knowing your past medical history, any medicines that you are taking, and any allergies or problems that you have had with your medical care in the past. Please be sure to include the names of your primary care and other physicians involved in your care so we can coordinate your care with them.

Please be aware that your physician co-pay will be collected at the time of your visit. You may pay by cash, personal check, Visa, or MasterCard. Since the professional practice of Annapolis Thoracic Surgery Associates is a program within the DeCesaris Cancer Institute at Anne Arundel Medical Center, a separate facility bill charge will be sent from Anne Arundel Medical Center. If you are responsible for any or all of this facility charge, you will be billed following your visit. You will not be required to pay this at the time of your physician visit.

Should you have questions pertaining to insurance coverage such as pre-certification, co-pay amounts, or eligibility, you can contact our office at 443-481-3300. If there are questions after your insurance company or you have received the bill, you can contact our Billing Department for Anne Arundel HealthCare Enterprises at 443-481-6538.

Inquiries regarding Hospital Facility Charges from Anne Arundel Medical Center may be directed to Patient Financial Services at 443-481-6500 Monday – Friday from 8:30 a.m. – 5:00 p.m. If you are unable to pay your bill, Anne Arundel Medical Center offers financial assistance based on family
income levels. Financial reductions and interest free payment plans are available. To apply for financial assistance or establish a payment plan please contact the hospital’s Financial Counseling office at 443-481-1401.

We look forward to caring for you and will be happy to answer any questions you may have for us by calling the numbers listed above.

Sincerely,

Kevin Pollock
Practice Manager
Annapolis Thoracic Surgery Associates

PLEASE REMEMBER TO BRING THE FOLLOWING:

- All health insurance cards
- Picture Identification
- Guarantor Information/Insurance Subscriber and your treatment referral, should your insurance company require one.
  - If you are unsure if you need a referral, please contact your insurance company.
- Your Pharmacy name, location, telephone, and fax numbers
- Your Primary Care and other Physician Contact Information(form enclosed)
- Completed New Patient History Form (form enclosed)
- Copies of Medical Reports, Diagnostic Tests, X-rays
New Patient History Form

Patient Name: ___________________________ Sex: M / F Date of Birth: ____________
Address: ___________________________ City: ___________ Zip: ________
Home Phone: ___________ Cell Phone: ___________ Work Phone: ___________

Emergency Contact: ___________________________ Relationship to Patient: ___________
Home Phone: ___________ Cell Phone: ___________ Work Phone: ___________

Referring Physician: ___________ Phone: ___________ Fax: ___________
Primary Care Physician: ___________ Phone: ___________ Fax: ___________

Reason for Visit: ___________________________________________________________________
_________________________________________________________________________________

Symptoms: (please check all that apply)

☐ cough
☐ sputum / phlegm production
☐ blood in sputum / hemoptysis
☐ wheezing
☐ pain with breathing
☐ shortness of breath
☐ difficulty breathing at rest
☐ difficulty breathing walking on flat surface
☐ difficulty breathing walking up stairs
☐ chest pain
☐ difficulty swallowing
☐ pain with swallowing
☐ weight loss: how many pounds? _________
☐ loss of appetite
☐ nausea
☐ fevers
☐ chills
☐ night sweats
☐ constipation
☐ diarrhea
☐ other symptoms? ________________________
_________________________________________________________________________________

Past Medical History:

☐ cancer: (types) ___________________________
☐ asthma
☐ COPD / emphysema
☐ bronchitis
☐ pneumonia
☐ sleep apnea: use machine at night? Yes / No
☐ tuberculosis
☐ high blood pressure / hypertension
☐ prior stress test: location/date ______________________
☐ heart attack / myocardial infarction
☐ prior heart catheterization
☐ prior heart stent / balloon angioplasty
☐ heart rhythm problems / atrial fibrillation
☐ blood clots in legs / DVT
☐ blood clots in lungs / pulmonary embolism
☐ diabetes
☐ excessive bleeding
☐ heartburn / reflux
☐ kidney disease
☐ liver disease: hepatitis / cirrhosis
☐ stroke
☐ prior blood transfusion
☐ prior colonoscopy: date ________________
☐ prior mammogram: date ________________
### Past Surgical History:

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<th>Surgery</th>
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Prior difficulty with anesthesia? Yes / No

If yes, nature of problem: ________________________________

### Medication Allergies:

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<th>Medication</th>
<th>Reaction/Allergy</th>
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### Food/Environmental Allergies:

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### Current Medications:

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<th>Dose</th>
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Annapolis Thoracic Surgery Associates

Social History:
Occupation: ____________________________  □ Retired?  □ Disabled?
Marital Status: single / married / divorced / widowed / separated
Do you have children? □ No  □ Yes  if Yes, how many? _____  Ages: ________________
Who lives with you at home? ____________________________
Is this visit related to Worker’s Compensation or Motor Vehicle Accident? □ No  □ Yes
Do you drink alcohol? □ No  □ Yes  if Yes, what kind? (e.g. beer, wine, etc.) ________________
  Approximately how many drinks per week? ________________
Prior exposure to:
  Asbestos? □ No  □ Yes  □ Unsure
  Tuberculosis? □ No  □ Yes  □ Unsure
  Radon? □ No  □ Yes  □ Unsure
  Other? □ No  □ Yes  □ Unsure  if Yes, type of exposure: ____________________________

Smoking Habits:
Have you ever smoked? □ No  □ Yes
Do you currently smoke? □ No  □ Yes
Have you smoked in the past year? □ No  □ Yes
Have you smoked more than 100 cigarettes in your lifetime? □ No  □ Yes
What do / did you smoke? □ Cigarettes  □ Cigars  □ Pipe  □ Other ________________
  How much do you / did you smoke? ________________
  What year did you start smoking? ________________  Age? ______
  What year did you quit smoking? ________________  Age? ______
  Why did you try to quit? ____________________________
  Did you try any of the following to help you quit?
    □ Chantix  □ Another pill ________________  □ Patch  □ Gum  □ Nothing, quit on my own
Have you spent a lot of time around others while they are smoking? □ No  □ Yes
Are you interested in us helping you to quit smoking? □ No  □ Yes

Family History:
□ Cancer:
  (include mother/father’s side) □ high blood pressure  □ diabetes
  □ heart disease  □ kidney disease  □ bleeding disorder
□ Other:

Thank you for your time in completing this form. Please sign: ____________________________
Patient’s Signature
# Physician’s List

Please provide a list of all of your physicians with complete name, address, and contact information so that we can update each of them with your progress.

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<tr>
<th>Physician Name</th>
<th>Specialty</th>
<th>Address</th>
<th>City</th>
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Important Co-Pay Information
Please read carefully and sign and date below.

We are an ambulatory office at Anne Arundel Medical Center. Your insurance company(s) will receive two charges for services rendered in this office; one for the physician’s professional service and one for the facility in which the service is rendered. Depending on your insurance and policy, you may receive a bill for some portion of the Facility Charge from Anne Arundel Medical Center.

When applicable, your co-payment for Professional Services will be collected on the date of service. If your insurance company deems that you are responsible for any portion of your Facility Charge, you will receive a bill from Anne Arundel Medical Center. If you have any questions, please feel free to ask our front desk staff for more information.

__________________________________________
Printed Name

__________________________________________    ______________________
Signature                                      Date