Annapolis Thoracic Surgery Associates

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**

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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 _____

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Past Surgical History: (please list all surgeries)

	Year	Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Prior difficulty with anesthesia? Yes / No If yes, nature of problem: _____

_____

Medication Allergies: Yes / None Known

	Medication	Reaction/Allergy
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Food/Environmental Allergies:

Yes / None Known

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Medications: (please list all medications with dose and frequency)

	Medication	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____

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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:

	Type	Relationship to You (include mother/father's side)		Relationship
□ Cancer:			□ 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.

Physician Name: ____ Specialty: _______________________
Address: ____
City: ________________________________ State: _________________________ Zip: _______________
Office Phone: ________________________ Fax: __________________________

Physician Name: ____ Specialty: _______________________
Address: ____
City: ________________________________ State: _________________________ Zip: _______________
Office Phone: ________________________ Fax: __________________________

Physician Name: ____ Specialty: _______________________
Address: ____
City: ________________________________ State: _________________________ Zip: _______________
Office Phone: ________________________ Fax: __________________________

Physician Name: ____ Specialty: _______________________
Address: ____
City: ________________________________ State: _________________________ Zip: _______________
Office Phone: ________________________ Fax: __________________________

Physician Name: ____ Specialty: _______________________
Address: ____
City: ________________________________ State: _________________________ Zip: _______________
Office Phone: ________________________ Fax: __________________________

Physician Name: ____ Specialty: _______________________
Address: ____
City: ________________________________ State: _________________________ Zip: _______________
Office Phone: ________________________ Fax: __________________________

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