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Welcome to North Suburban Pulmonary and Critical Consultants. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients.

You will need to bring the following items to your appointment:

- Your insurance card(s) and a photo ID
- The enclosed forms completed that include a list of your medications and your pharmacy information. **The pages are double sided.**
- Any chest x-rays or CT scans – the disk and report. If these tests were at Advocate Lutheran General, you will just need to provide the date. Your physician can view them online.
- Any other information pertaining to your chest such as medical records or Pulmonary Function Tests
- A referral from your primary care physician if your insurance is an HMO
- **Please bring all medications (pill bottles, inhalers, etc.)**

You will need to bring your insurance card and a photo ID with you for **each** appointment. Please let our staff know if you any information changes between your appointments.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Welcome to our practice and thank you for choosing our practice for all your health care needs.

Patient Information: Date: _____

Name_____

Date of Birth: _____ please circle: Male Female

Marital status: _____

Address:_____

Home Phone#: _____ Cell Phone#: _____

Email address: _____

Primary Care Physician: Name _____

Address_____

Phone #_____

Pharmacy information:

Local: *Mail Order:*

Name: _____ Name: _____

Address: _____ Address: _____

Phone#_____ Phone#_____

Known Drug Allergies:

_____

_____

_____

_____

Medications: Prescribed and over the counter

Name	Strength	Dosage	