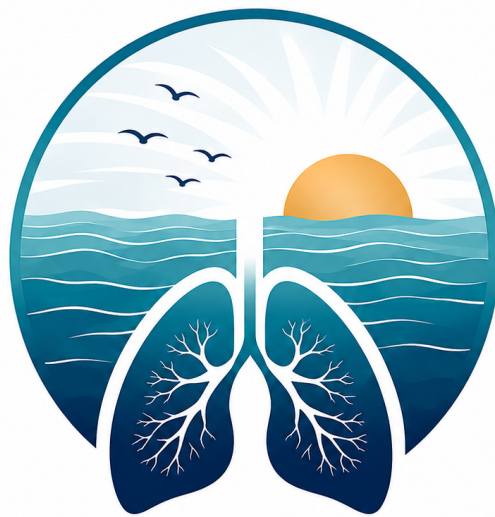




OCEANSIDE

— P U L M O N A R Y —

3515 SE Willoughby Blvd.

Stuart, FL 34994

772-210-2037

oceansidepulmonary.com

Monday-Friday 9 AM - 5 PM



New Patient Packet

Oceanside Pulmonary — Pulmonary & Internal Medicine

Your Care Team



Dr. Nicholas James

*Pulmonary & Internal
Medicine*



Visit Us

Address	3515 SE Willoughby Blvd., Stuart, FL 34994
Phone	772-210-2037
Website	oceansidepulmonary.com
Hours	Monday – Friday, 9 AM – 5 PM

What to Bring to Your Visit

- Photo ID and insurance card(s)
- A list of current medications and dosages
- Referral or recent records from other providers, if applicable
- Completed sections of this packet



Welcome

We're glad you're here

Welcome to Oceanside Pulmonary

Our mission is to provide compassionate, high-quality, evidence-based care in primary care and pulmonary medicine. We are committed to individualized care, improving access for our patients, and building strong, lasting relationships — focusing on prevention, accurate diagnosis, and long-term health outcomes.

Our Commitment to You

- **Individualized Care**

Every treatment plan is built around you — your health history, your goals, and your life.

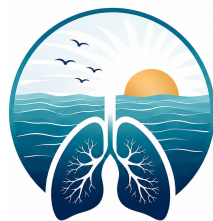
- **Improving Access**

We work to make it easier for patients to get the timely care they need.

- **Strong Relationships**

We invest in getting to know our patients so we can care for them well over time.

We look forward to caring for you and your family.



PATIENT DEMOGRAPHICS

Patient Information

Full Name: _____

Date of Birth: _____ **Sex:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Email: _____

Employer: _____

Preferred Pharmacy: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____



INSURANCE & FINANCIAL INFORMATION

Insurance Information

Primary Insurance: _____

Policy #: _____ **Group #:** _____

Secondary Insurance: _____

Assignment of Benefits

I authorize payment of medical benefits directly to Oceanside Pulmonary.

Signature: _____ **Date:** _____

Financial Policy

- Payment due at time of service
- Copays, deductibles, coinsurance are the responsibility of the patient
- Insurance billing is not a guarantee of payment
- Self-pay due at visit
- \$50 no-show fee
- Credit card on file required
- Balances may be sent to collections

Signature: _____ **Date:** _____



CONSENTS

Consent to Treat

I consent to evaluation and treatment by Oceanside Pulmonary providers.

Signature: _____

Date: _____

HIPAA Acknowledgment

I acknowledge receipt of the Notice of Privacy Practices.

Signature: _____

Date: _____

Medical Records Release

I authorize release of my records for treatment and healthcare operations.

Signature: _____

Date: _____

AI Scribe Consent

☐ I consent to AI-assisted documentation

☐ I do NOT consent

Signature: _____

Date: _____



MEDICAL & PULMONARY HISTORY

Medical History

Conditions: _____

Surgeries: _____

Family History: _____

Social History:

Alcohol use: ☐ Current ☐ Former ☐ Never

Illicit drug use: ☐ Current ☐ Former ☐ Never

Smoking history: ☐ Current ☐ Former ☐ Never years: ____ packs/day: ____

Pulmonary History

Smoking: years: ____ packs/day: ____

☐ Current ☐ Former ☐ Never

Vaping: ☐ Yes ☐ No

Sleep Apnea: ☐ Yes ☐ No

CPAP/BiPAP: ☐ Yes ☐ No

Exposures (work/environment):

Pets:



MEDICATIONS & ALLERGIES

Medications

Medication	Dose	Frequency

Allergies

Allergen	Reaction



REVIEW OF SYSTEMS

Current Symptoms

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fever
- ☐ Fatigue
- ☐ Weight loss
- ☐ Swelling

Other: _____



FINAL SIGNATURE PAGE

Patient Acknowledgment

By signing below, I confirm that I have reviewed and agree to:

- Financial Policy
- Consent to Treat
- HIPAA Acknowledgment
- Assignment of Benefits
- AI Scribe Consent

Patient Name: _____

Signature: _____

Date: _____