PULMONOLOGY ASSOCIATES INC. PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name:_____ First: _____ Middle:_____

Address: _____ Apt:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Work Phone #:_____ Cell #:_____

May We Leave a Message? Y or N Preference? Home/Work/Cell _____

Social Sec #:_____Date of Birth:_____ Sex: M or F EMAIL_____

Marital Status: Single Married Divorced Widowed Spouses Name:_____

Race: American Indian Asian African American Native Hawaiian White Other _____

Ethnicity: Hispanic/Latin Not Hispanic/Latino Other _____ **Preferred Language:** _____

INSURANCE INFORMATION:

Insurance Co: _____Policy #:_____Group #: _____

Subscriber Information (if different from patient):

Name:_____ Social Sec #: _____

Date of Birth: _____ Relationship to Patient:_____

Second Insurance:_____ Policy#:_____Group#:_____

PATIENT EMPLOYMENT INFORMATION:

Employer: _____ Occupation:_____

Address, City, State:_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name:_____Relationship: SP Parent Child Other

Address, City, State: _____

Home Phone #:_____ Work Phone #:_____ Cell #:_____

FAMILY PHYSICIAN:_____

Address, City, State _____Phone#_____

REFERRING PHYSICIAN:_____

Address, City, State_____Phone#_____

PHARMACY INFORMATION:

Local Pharmacy :_____ Phone #: _____

Address, City, State: _____

Mail Order Pharmacy :_____ Phone #: _____

Address, City, State: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Pulmonology Associates, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any deductibles or co-Insurance payments and non-covered services.

_____ _____

Patient or Guardian Signature Date