PULMONARY
ASSOCIATES, PC
Pulmonary critical care and sleep medicine

Date ___ / ___ /___

PLEASE PRINT

PATIENT INFORMATION	
Patient Name	Phone
Address	DOB _____ / _____ / _____
City, State, Zip	
SSN ______- _______ - _______	❍ Male ❍ Female
Marital Status: ❍ Single ❍ Married ❍ Widowed ❍ Divorced ❍ Other:	

EMPLOYER'S INFORMATION	
Employer	Occupation
Employer's address	Phone
City, State, Zip	

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN
Name	Name
Address	Address
City, State, Zip	City, State, Zip

SPOUSE INFORMATION	
Spouse's Name	SSN ________- ________- ________
Employer	Phone

EMERGENCY CONTACT	
Name	Phone:
Address	City, State, Zip

If person responsible for payment is other than patient, please complete the following:	
Person Responsible	SSN ________- ________- ________
Relationship to patient	Occupation
Employer	Phone
Employer's address	
City, State, Zip	

INSURANCE: If you wish this office to file insurance, fill out the insurance section completely and sign below. If you have questions concerning your insurance, please see the billing office.		
****REQUIRED**** TRICARE Sponsor's SSN _______- _______ - _______		
Primary insurance	ID#	Gp#
Name of Subscriber		Copay Amt.
Secondary insurance	ID#	Gp#
Name of Subscriber		Copay Amt.

I authorize the release of medical information from any other medical provider needed for treatment by Pulmonary Associates.	**I authorize payment of medical benefits to Pulmonary Associates. I am also aware if my insurance does not cover services, I am responsible for all charges.**
______________________________ Patient's signature or guardian	______________________________ Patient's signature