PULMONOLOGISTS P.C.

Date

PATIENT REGISTRATION *(Please Print)*

REFERRED BY

PATIENT NAME FIRST	MIDDLE	LAST	HOME PHONE NO. ( )

SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH	AGE	MARITAL STATUS ☐ M ☐ S ☐ W ☐ D ☐ Sep	SOCIAL SECURITY NUMBER	WORK PHONE NO. ( )

ADDRESS Street	City	State	Zip	CELL PHONE NO. ( )

ARE YOU ☐ Employed ☐ Full-Time Student ☐ Part-Time Student	OCCUPATION OR, IF STUDENT, GRADE

EMPLOYER OR SCHOOL NAME & ADDRESS Street	City	State	Zip

E-MAIL ADDRESS	PHARMACY NAME	PHARMACY PHONE NO. ( )

PERSON FINANCIALLY RESPONSIBLE (If different from above)

NAME	PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Child ☐ Spouse ☐ Other _____	OCCUPATION
ADDRESS Street	SOCIAL SECURITY NUMBER	HOME PHONE NO. ( )
City State Zip	EMPLOYER NAME	EMPLOYER PHONE NO. ( )

PRIMARY INSURANCE

If no insurance please check ☐

INSURANCE COMPANY			INSURED (If other than patient please complete)		
INSURANCE COMPANY NAME OR MEDICARE INFORMATION			POLICY IN NAME OF (Insured)		HOME PHONE NO. ( )
POLICY NUMBER	GROUP NUMBER		INSURED'S ADDRESS Street		
INSURANCE COMPANY ADDRESS Street			City	State	Zip
City	State	Zip	PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Child ☐ Spouse ☐ Other _____	DATE OF BIRTH	SEX ☐ M ☐ F
INSURANCE COMPANY PHONE NUMBERS Verifying ( )	Claim ( )		EMPLOYER'S NAME & PHONE NO.		SOC. SEC. NO. OF INSURED

SECONDARY INSURANCE

INSURANCE COMPANY			INSURED (If other than patient please complete)		
INSURANCE COMPANY NAME OR MEDICARE INFORMATION			POLICY IN NAME OF (Insured)		HOME PHONE NO. ( )
POLICY NUMBER	GROUP NUMBER		INSURED'S ADDRESS Street		
INSURANCE COMPANY ADDRESS Street			City	State	Zip
City	State	Zip	PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Child ☐ Spouse ☐ Other _____	DATE OF BIRTH	SEX ☐ M ☐ F
INSURANCE COMPANY PHONE NUMBERS Verifying ( )	Claim ( )		EMPLOYER'S NAME & PHONE NO.		SOC. SEC. NO. OF INSURED

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NO. ( )
FAMILY DOCTOR		PHONE NO. ( )

If patient is under 18 years of age, please complete the following:

ACCOMPANYING ADULT'S NAME	RELATIONSHIP TO PATIENT	SIGNATURE

INSURANCE AUTHROIZATION AND ASSIGNMENT

I hereby authorize Pulmonoligists, P.C., or the physicians thereof, to apply for benefits for covered services rendered by them. If assignment is accepted I request payment from insurance carrier to be made directly to the above named group.

I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information to my insurance carrier or above named group, or to my referring physician. This authorization may be revoked by my insurance carrier or me at any time in writing.

I understand and agree to be responsible for any portion of this claim that for any reason is not covered by my insurance. I further understand that any legal fees incurred to collect this claim are my responsibility as well as any service charges assessed to accounts with returned checks or invalid credit card purchases.

Signature Responsible Party Date

Patient Date