WELCOME TO PULMONARY AND CRITICAL CARE ASSOCIATES

PATIENT REGISTRATION INFORMATION

Patient's Name: _____ Date of Birth _____
Last First Middle Initial

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

SSN# _____ □ Male □ Female □ Minor □ Single □ Married □ Divorced □ Widowed □Separated

Email Address (We need for our online portal system)_____

Employer _____ Occupation _____

Address _____ State _____ Zip Code _____

Spouse/Parent _____ Home Phone _____ Cell Phone_____
Circle one
Emergency Contact _____ Relationship _____ Phone_____
□ Same as Spouse/Parent

INSURANCE INFORMATION

Primary Insurance _____ Insured's Name _____
Last First Initial

Relationship to Patient _____ SSN # _____ Date of Birth _____

Secondary Insurance _____ Insured's Name _____
□ I do not have secondary insurance Last First Initial

Relationship to Patient _____ SSN # _____ Date of Birth _____

MEDICAL INFORMATION

Reason for Visit _____

Primary Doctor _____ Referring Doctor _____

Other Doctors Treating You _____

When confirming appointments, which # would you like for us to call? Home Cell Other _____

PATIENT AUTHORIZATION

I authorize my (or my child's) insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Pulmonary & Critical Care Associates, or any of its affiliates or agents, lenders, or any third party servicer acting for Pulmonary & Critical Care Associates, or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to Pulmonary & Critical Care Associates and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. *I **further** agree to pay for any **missed appointments of which I did not notify the medical office within 24 hours.***

_____ Date _____
Signature of Patient or parent/guardian if minor

PLEASE USE BLACK INK ONLY