PULMONARY CRITICAL CARE AND SLEEP SPECIALISTS, P.A.

Date: _____

PATIENT INFORMATION

Name of Patient: _____ Male ☐ Female ☐
Last Name First Name Middle Name

Date of Birth: _____/_____/_____ Age: _____ **S.S. #:** _____ - _____ - _____
Month Date Year

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ Mobile: (_____) _____

Marital Status: Single Married Divorced Separated Widowed

Email Address:_____ Employer:_____

Employment status: [ ] Fulltime [ ] Part time [ ] Retired [ ] Unemployed Work Phone: (___)_____

Employer's Address: _____ City: _____ State: ____ ZIP: _____

Contact Person in case of Emergency: _____ Phone: (_____) _____

Relationship:_____

SPOUSE INFORMATION OR PARENT'S INFORMATION IF SINGLE

Name: _____ Date of Birth: _____/_____/_____ S.S. #: _____- _____- _____
Last First Middle Month Date Year

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ Mobile: (_____) _____

Employment: _____ Work Phone: (_____) _____

Employer's Address: _____ City: _____ State: ____ ZIP: _____

PCP (Primary Care Physician): _____ Phone: (_____) _____

Referring Doctor: _____ Phone: (_____) _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: (_____) _____

Pharmacy Address: _____ City: _____

State: _____ ZIP: _____

Mail Order Pharmacy (if available**):** _____ Phone: (_____) _____

Additional Pharmacy Information: _____

PULMONARY CRITICAL CARE AND SLEEP SPECIALISTS, P.A.

Preferred **Language: _____**

Please answer these optional questions for gathering pooled demographic data:

Ethnicity (Circle one)**:** Hispanic Non-Hispanic

Race: Please check one of the following

□ African American □ American Indian/ Alaskan Native □ Asian □ Caucasian

□ Hispanic □ Native Hawaiian □ Other Pacific Islander □ Other Race

INSURANCE INFORMATION (Circle one): Please give card to receptionist

Name of Insurance Company (Circle):

Aetna Blue Cross Cigna Humana Medicaid Medicare Tricare United Health

If other, give name:_____

If you are not the primary insurance holder, please provide the following information:

Name of Guarantor: _____ Relationship to patient: _____

S.S. # of Guarantor: _____ - _____ - _____ DOB: _____

Guarantor's Phone #: (_____) - _____ - _____;**Alt. Ph. #:** (_____) _____- _____

Guarantor's Address (if different from patient's): _____

City: _____ State: _____ ZIP: _____

I hereby acknowledge that the information provided above is accurate to the best of my knowledge:

Signature of Patient: _____ Date: _____

WHEN WE HAVE CORRECT ADDRESS AND INFORMATION, WE FILE INSURANCE AUTOMATICALLY
PLEASE FILL OUT THIS ENTIRE FORM