Welcome to Our Office

PULMONARY INTERNISTS, P.A.

PATIENT INFORMATION

PLEASE PRINT

Name _____	Date _____
Address _____	Age _____ Sex _____
City _____ State _____ Zip _____	Marital Status _____
Home Phone _____ Cell # _____	Date of Birth _____
Employed by _____	Account # _____
Employer's Address _____	Driv. Lic. # _____
Occupation _____	Pharmacy # _____
Work Phone _____	Soc. Sec. # _____

Spouse/Parent _____	Date of Birth _____
Employment _____	Work Phone _____
Occupation _____	Occupation _____

Emergency Contact (not living at above address) _____	Phone # _____
Address _____	Relationship _____

Allergies

Referring Dr. _____ Primary Care Physician _____

Medications _____

_____

INSURANCE INFORMATION

Please Keep Your Cards Out . . . We Need to Photocopy Them

Primary Insurance

Name of Insurance Co. _____	Policyholder's Name _____
Policy ID # _____	Plan # _____
Insurance Co. Address _____	Soc. Sec. # _____

Secondary Insurance

Name of Insurance Co. _____	Policyholder's Name _____
Policy ID # _____	Plan # _____
Insurance Co. Address _____	Soc. Sec. # _____

I hereby authorize the above named physician to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named physician of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by insurance or Medicare. I agree that in the event that my account must be turned over to an attorney for collection, that I will be responsible for attorney's fees and court cost and interest. This signature also serves as authorization should I wish to apply my balance to MasterCard/Visa. A photocopy of this assignment is to be considered as valid as an original. I agree that if my account is not paid in full by either my Insurance Company AND/OR myself, I will be charged interest and rebilling charges monthly until my account is Paid in Full.

Signature of Person Responsible for Payment