ADVANCED PULMONARY CRITICAL CARE

PATIENT INFORMATION

Thank you for selecting us to be a part of your healthcare team. We know that this is an important decision and we will work hard to justify your confidence in us.

PLEASE PRINT

NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER
HOME ADDRESS			CITY		STATE	ZIP CODE
HOME PHONE	CELL PHONE / PAGER	MARITAL STATUS ☐ S ☐ M ☐ OTHER	DRIVER'S LICENSE NO.	OCCUPATION	STUDENT ☐ FULL TIME ☐ PART TIME	
EMPLOYER/SCHOOL NAME			EMPLOYER/SCHOOL ADDRESS			
CITY	STATE	ZIP CODE	BUSINESS PHONE	EMAIL ADDRESS		
IN CASE OF EMERGENCY, NOTIFY			PHONE NO.	DRUG ALLERGIES		
HOW DID YOU LEARN ABOUT US: ☐ DOCTOR REFERRAL ☐ FRIEND REFERRAL ☐ YELLOW PAGES ☐ WEBSITE ☐ INSURANCE BOOKLET / WEBSITE			REFERRING DOCTOR	PRIMARY CARE PHYSICIAN		

POLICY HOLDER INFORMATION

RESPONSIBLE PARTY	DATE OF BIRTH	SEX	DRIVER'S LICENSE NUMBER	SOCIAL SECURITY NUMBER
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	BUSINESS PHONE	EMPLOYER/SCHOOL NAME		
EMPLOYER/SCHOOL ADDRESS		CITY	STATE	ZIP CODE

INSURANCE INFORMATION

PRIMARY INSURANCE TYPE ☐ PPO ☐ HMO ☐ MEDICARE ☐ MEDICAID ☐ INDEMNITY			SECONDARY INSURANCE TYPE ☐ PPO ☐ HMO ☐ MEDICARE ☐ MEDICAID ☐ INDEMNITY		
PRIMARY INSURANCE COMPANY NAME			SECONDARY INSURANCE COMPANY NAME		
INSURANCE COMPANY ADDRESS			INSURANCE COMPANY ADDRESS		
GROUP NUMBER	POLICY NUMBER		GROUP NUMBER	POLICY NUMBER	
SUBSCRIBER'S NAME	SUBSCRIBER'S SSN NO.	SUBSCRIBER'S DOB	SUBSCRIBER'S NAME	SUBSCRIBER'S SSN NO.	SUBSCRIBER'S DOB
PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER			PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		

INJURY / ACCIDENT INFORMATION

IF INJURY/ACCIDENT ☐ HOME ☐ WORK ☐ MOTOR VEHICLE/STATE _____ ☐ OTHER	DATE OF ONSET	DATE LAST WORKED
IF REPRESENTED BY ATTORNEY-NAME OF ATTORNEY	ADDRESS	PHONE NO.

PAYMENT IS EXPECTED AT TIME OF SERVICE. PLEASE BE PREPARED TO PAY ALL COPAYMENT AND DEDUCTIBLE AMOUNTS METHOD OF PAYMENT ☐ CASH ☐ CHECK ☐ BANK CARD

RELEASE OF MEDICAL RECORDS AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize the release of requested medical information and / or records to my primary care physician, insurance company, third party review organization, peer review physician, employer or their representatives.

I understand that I am responsible for all charges not paid by my insurance company, subject to any contractual limitations between my physician and insurance company or managed care network.

I understand that I am responsible for promptly responding to my insurance company to provide any additional information they may request regarding my treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in my account becoming due and payable, in full, immediately.

I will be prepared to present my insurance card and proof of identity (e.g. driver's license) at each visit. I will provide a change of address, telephone number and / or insurance information any time a change occurs.

SIGNATURE OF RESPONSIBLE PARTY	DATE