Pulmonary & Sleep Associates of Huntsville

PATIENT REGISTRATION INFORMATION

Last Name _____ First Name _____ MI ___ Sex: ❒ M ❒ F

Home Street Address _____ City _____ State _____ Zip Code _____

Mailing Address (if different) _____ City _____ State _____ Zip Code _____

Date of Birth _____ Social Security # _____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Child

Home Phone # _____ Cell Phone # _____ E-mail Address _____

Patient's Employer _____ Work Phone # _____

Spouse/Parent (if minor child) Name _____ Spouse/Parent DOB _____ Spouse/Parent SSN _____

Spouse/Parent (if minor child) Employer _____ Spouse/Parent Work Telephone # _____

Referring Physician _____ Primary Care Physician _____

Emergency Contact (other than listed above) _____ Relationship _____ Phone # _____

Pharmacy _____ Pharmacy Location _____ Pharmacy Phone # _____

Insurance Information (Copay: $ _____)

Primary Insurance Company _____ Contract / ID # _____ Group # (if applicable) _____

Policyholder's Name _____ DOB _____ SSN _____

Secondary Insurance Company _____ Contract / ID # _____ Group # (if applicable) _____

Policyholder's Name _____ DOB _____ SSN _____

INSURANCE IS FILED AS A COURTESY – PAYMENT IS EXPECTED AT TIME OF SERVICE – THANK YOU

See Separate Pages for Consent to Treat / Authorizations / Financial Policies

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