

PERSONAL INFORMATION

Name: _____ MI _____
Address: _____
City: _____ State: _____ ZIP: _____
Home #: () _____ Cell #: () _____
Work #: () _____
SS#: _____
DOB: _____ Sex: M / F

Employer: _____
Employer Address: _____
City: _____ State: _____ ZIP: _____
Employed: Full Time / Part Time / Retired (circle one)
Student: Full Time / Part Time / N/A (circle one)

SPOUSE INFORMATION

Marital Status: S / M / D / W

Spouse Name: _____
Spouse SS#: _____ DOB: _____
Spouse Work #: () _____

Spouse Employer: _____
Employer Address: _____
City: _____ State: _____ ZIP: _____

INSURANCE INFORMATION

Primary Insurance Information

Company: _____
Group #: _____
Contract #: _____
Policy Holder: _____
Policy Holder SS#: _____ DOB: _____
Policy Holder Employer: _____

Secondary Insurance Information

Company: _____
Group #: _____
Contract #: _____
Policy Holder: _____
Policy Holder SS#: _____ DOB: _____
Policy Holder Employer: _____

EMERGENCY CONTACT

Name: _____
Address: _____
City: _____ State: _____ ZIP: _____

Relationship to patient: _____
Home #: () _____ Cell #: () _____
Work #: () _____

REFERRAL INFORMATION

Referring Physician: _____
Phone: _____

Primary Physician: _____
Phone: _____

I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

PLEASE FILL OUT BACKSIDE →→→→

Patient Name: _____ Date: _____

Dear Patient:

In order for us to provide information regarding your personal care to any individual other than your referring physicians, we must receive a signed release from you indicating that you are authorizing us to share information. This may include physicians who provide care for you, family members including your spouse, children, significant other, etc. We ask that if you authorize the release of information to anyone that you write their name in the space provided below and update at your future appointments.

Thank you,
Pulmonary & Critical Care Consultants, PLLC

I hereby give my permission for Pulmonary & Critical Care Consultants, PLLC to release medical information regarding personal care to:

Signature of Patient: _____ Date: _____

The following information will assist us in your care and in communications with you, at the same time protecting your confidentiality. Please circle "yes" or "no" and provide the necessary information.

I give my permission for Pulmonary & Critical Care Consultants, PLLC to:

- Yes No Leave a message confirming upcoming appointments.
- Yes No Leave a message with test results on answering machine # _____.
- Yes No Leave a message with a family member answering my phone.
- Yes No Leave a message requesting a return call on my work phone # _____.
- Yes No Leave a message requesting a return call on my home phone # _____.
- Yes No Fax test results information regarding my condition # _____.
- Yes No May fax information to and from any provider your physician may refer you to.

Signature of Patient: _____ Date: _____