PUEBLO PULMONARY ASSOCIATES

PATIENT NAME:_____
Last First MI

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE#:_____BIRTH DATE:_____AGE:_____SEX:_____

SOCIAL SECURITY#: _____ REFERRING PHYSICIAN:_____

MARITAL STATUS (please circle one): M W D S SPOUSE'S NAME:_____

EMERGENCY NOTIFICATION

NAME:_____PHONE#:_____
(Please name someone NOT at the same address as yours)

RESPONSIBLE PARTY, IF DIFFERENT FROM PATIENT

NAME:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE#:_____RELATIONSHIP TO PATIENT:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

NAME OF POLICY HOLDER:_____

INSURANCE ID#:_____GROUP#:_____

POLICY HOLDERS EMPLOYER:_____

SECONDARY INSURANCE:_____

NAME OF POLICY HOLDER:_____

INSURANCE ID#:_____GROUP#:_____

POLICY HOLDERS EMPLOYER:_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Pueblo Pulmonary Associates to release any information acquired in the course of my examination or treatment to the insurance company listed above or Medicare or Medicaid. I also understand that I am personally responsible for the costs of the services rendered.

SIGNATURE:_____DATE:_____

MEDICATIONS

Please list your medications below and bring all bottles with you.

Medications* Dosage Times/day

*Don’t forget to include vitamins and health supplements.