



PATIENT INFORMATION

Pulmonary Medicine

Date _____

Please fill out completely and return to the receptionist with your insurance card and a photo ID such as a driver's license.

Name _____ Date of Birth _____

Age _____ Telephone # _____ Social Security Number _____

Address _____
Street _____ City _____

State _____ Zip Code _____ Email Address _____

Marital Status S _____ M _____ O _____ Spouse's Name _____

If Under 18, Parent/Guardian _____

Employer _____ Employer's Telephone # _____

Primary Physician Referred By _____

Primary Insurance Company _____

Insurance Name Policy Holder _____

Relation to Patient _____ Date of Birth _____ SS# _____

Insurance Address _____

Policy # _____ Group # _____ Phone # _____

Secondary Insurance Company _____

Relation to Patient _____ Date of Birth _____ SS# _____

Insurance Address _____

Policy # _____ Group # _____ Phone # _____

Authorization to Release Information

I hereby authorize Howard Diener MD, John Swisher MD or Rose Bright MD to release any medical or incidental information that may be necessary for either medical care or to fulfill requirements as requested. I authorize Suncoast Lung Center to send information via fax if necessary for continuity of care.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Patient _____ Date _____

Parent/Guardian _____