MAINLAND
PULMONARY ASSOCIATES

PATIENT INFORMATION:

First Name_____M.I._____Last Name_____

Sex: M or F Date of Birth_____Age_____

Are you: ____Single ____Married ____Divorced _____Legally Separated _____Widowed

Social Security #:_____ Driver's License#:_____

Home (mailing) Address: _____

Apt#:_____City:_____State:_____ Zip:_____

Home Phone:(____)_____Work Phone: (____)_____Cell Phone: (_____)_____

Student Status: ___Full Time ___Part Time_ Name of School: _____

Employment Status: ___Full Time ___Part Time ____Not Employed _____Retired

Employer:_____Occupation:_____

Work Address:_____City:_____State:_____Zip:_____

Email Address:_____

Primary Care Doctor: _____ Referring Doctor:_____

How Did You Hear About Us: _____

EMERGENCY INFORMATION:

Name: _____Relationship:_____Phone: _____

Address: _____City: _____State: _____Zip: _____

INSURANCE INFORMATION:

Primary Insurance: _____Phone #: _____

Policy number: _____Group number: _____

Insurer's Name (if other than patient): _____DOB: _____ SS#: _____

Secondary Insurance: _____Phone #: _____

Policy number: _____Group number: _____

Insurer's Name (if other than patient): _____DOB:_____SS#: _____

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I REQUEST PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE BENEFITS BE MADE ON MY BEHALF TO MAINLAND PULMONARY ASSOCIATES PLLC FOR ANY SERVICES FURNISH TO ME BY THEM, WITHOUT OBTAINING MY SIGNATURE OF EACH AND EVRY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS AND THAT YOU WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

Signature: _____Date: _____