Pulmonary and Medicine Associates 27472 Schoenherr Rd, Suite 100, Warren MI 48088 Phone: 586-751-8844

Patient Information Registration Form

Last Name: First Name: Middle Initial:

Date of Birth: Age: Sex: ☐M ☐F Social Security Number:

Home Phone: Cell Phone: Work Phone:

Address: City: State: Zip:

Status: ☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Minor

☐Partnered for ____ years Patient/Representative EMAIL address:

Employer/ School: Occupation:

Employer/ School Address: Employer/ School Phone:

Whom may we thank for referring you?

In case of an emergency who should be notified? Phone:

Primary Insurance Information

Person Responsible for Account: (If different from patient)	Last Name	First Name	Initial
Employer (of responsible party)	Occupation (of responsible party)	Business Address	Business Phone

Insurance Company:

Contract #/ Member ID: Group #:

Relation to Patient: Date of Birth: Soc.Sec#:

Address (if different from patients): Phone:

Secondary Insurance Information

Insurance Company:

Contract #/ Member ID: Group #:

Relation to Patient: Date of Birth: Soc.Sec#:

Address (if different from patients): Phone:

Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with (Insurance company): and assign directly to Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission.

Pulmonary and Medicine Associates may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient