# TEXAS LUNG CENTER, P.A.

## THIS FORM MUST BE COMPLETED BEFORE SEEING THE DOCTOR

NAME:_____ E-MAIL:_____D.O.B.:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SOCIAL SECURITY #:_____SEX:_____ MARITAL STATUS: OMODOSOWOLPOLS

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

LANGUAGE:_____ RACE:_____OCCUPATION:_____

SPOUSE:_____ HOME/CELL#:_____ WORK:_____

REFERRED BY:_____ PHONE:_____

DO YOU LIVE IN A SKILLED NURSING FACILITY? _____ HAVE HOSPICE CARE?_____

PRIMARY CARE DOCTOR (PCP):_____PHONE:_____

PCP's ADDRESS: _____

EMERGENCY CONTACT: _____ RELATION:_____PHONE:_____

(#1) PRIMARY INSURANCE: _____ NAME OF INSURED:_____

INSURED SS#_____ID#_____ GROUP#_____

(#2) SECONDARY INSURANCE:_____ NAME OF INSURED:_____

INSURED SS#_____ID#_____GROUP#_____

PHARMACY NAME:_____ADDRESS:_____PHONE#_____

ALL PAYMENTS AND CO-PAYS ARE DUE AT THE TIME SERVICES AR RENDERED. MAKE CHECKS PAYABLE TO: TEXAS LUNG CENTER P.A.. AUTHORIZATION TO RELEASE INFORMATION/AUTHORIZATION TO PAY: I HEREBY AUTHORIZE TEXAS LUNG CENTER, P.A.. TO RELEASE ANY INFORMATION ACQUIRED DURING THE COURSE OF MY EXASMINATION TO MY INSURANCE COMPANY AND/OR REFERRING PHYSICIAN. I ALSO AUTHORIZE PAYMENT DIRECTLY TO TEXAS LUNG CENTER, P.A. FOR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

**TO THE BEST OF MY KNOWLEDGE, THE ANSWERS CONTAINED HEREIN ARE TRUE AND CORRECT.**

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE