Pulmonary Consultants
6750 E Baywood Ave Suite #401
Mesa/Arizona 85206
Office : (480)835-7111 Fax : (480)-969-9345

PATIENT DEMOGRAPHIC FORM*

Social Security Number: _____E-mail:

Name (last, first, middle): _____

Primary Address: _____City_____State_____Zip_____

Secondary Address:_____City_____State_____Zip_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Gender: _____M_____F_____ Date of Birth: _____

Marital Status : S___M___D___W Ethnicity: i.e., Country of Origin :

Race: American Indian____Asian___Black____White_____Pacific Islander____Not Provided

Emergency Contact Info:
Name:_____Phone:_____Relationship:_____

PHARMACY:

Pharmacy Name:_____Phone _____

Pharmacy Address:_____

PHYSICIANS:

Primary Care Physician : _____Phone_____
Address:_____

Referring Physician: _____Phone_____
Address:_____

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**Please bring a copy of your health insurance card, if applicable, with you to your visit*

INSURANCES :

Primary Insurance Company : _____

Name of Policy Holder : _____ Date of Birth:_____

Patient Relationship to Insured:_____Insured SSN: _____

Secondary Insurance Company: _____

Name of Policy Holder: _____ Date of Birth:_____

Patient Relationship to Insured:_____Insured SSN: _____

Consent for Treatment & Insurance Assignment / Authorization

I hereby authorize Pulmonary Consultants, P.C., to furnish information to insurance carriers concerning my illness, and treatment. I hereby assign to the physicians ALL payments for medical services rendered to myself or dependent. I understand, I am responsible for ANY amount NOT covered by my insurance company. I am responsible for any unpaid amount and agree to pay court cost, including any attorney fees which are incurred in the collection process.

The patient or authorized representative recognizing the need for care consents to ALL or ANY services as ordered by the physicians, including lab procedure, medical treatment, minor or emergency surgical treatment, exam or other services rendered under specific instruction of the physician.

Signature of Responsible Party: Date:

_____ _____

Submit