



Pulmonary Associates of St. Augustine, P.A.

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Patient information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient name _____
LAST FIRST MI

SS # _____ M ___ F ___ Birthdate _____

Address _____ City _____ State _____ Zip code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Employer _____ Work Phone _____

Business Address _____
STREET CITY STATE ZIP

Person to contact in case of emergency _____ Phone _____ Relationship _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ SS# _____ Employer _____

Insurance Company _____ Group # _____ Insurance ID # _____

Do you have secondary insurance ? Yes ___ No ___ If yes, complete the following :

Name of insured _____ Relationship to patient _____

Birthdate _____ SS # _____ Employer _____

Insurance company _____ Group # _____ Insurance ID # _____

AUTHORIZATIONS AND RELEASES

I hereby authorize payment of all insurance benefits directly to Pulmonary Associates of St. Augustine. Any and all copays and coinsurances following insurance payments are due and payable by myself.

Signature of patient

Date

I authorize release of any information concerning my healthcare and any medical records requested by physicians providing my health care, advice, and treatment for the purpose of continuing care.

Signature of patient

Date

I have received and acknowledge HIPPA and privacy practices information.

Signature of patient

Date