



# Pulmonary Associates of St. Augustine, P.A.

KISHWAR HUSAIN,MD

JAVIER ADUEN,MD

300 HEALTHPARK BLVD. STE,4000, ST.AUGUSTINE, FL 32086  
TELEPHONE : 904-824-8666 FAX: 904-824-8933

## 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