PULMONARY CONSULTANTS & PRIMARY CARE PHYSICIANS MEDICAL GROUP, INC.

❑ Orange ❑ La Veta ❑ Tustin

Date / /

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Home Address: _____ City: _____ Zip: _____

Home Telephone: ( ) _____ Day Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Date of Birth: _____ Age: _____ Sex: ❑ Male ❑ Female

Social Security #: _____ Drivers License #: _____

Employer Name: _____ Occupation: _____

Employer Telephone: ( ) _____ Referred by: _____

Marital Status: ❑ Single ❑ Married ❑ Other _____

Primary Language Spoken: _____

SPOUSE INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ Sex: ❑ Male ❑ Female

Social Security #: _____

RESPONSIBLE PARTY INFORMATION

If someone other than patient is responsible for patient, complete this section.

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

IN THE EVENT OF AN EMERGENCY

Please list a friend or relative (other than spouse) we may contact.

Name: _____ Relationship: _____

Home Phone: ( ) _____ Business Phone: ( ) _____

PRIMARY INSURANCE COVERAGE FOR PATIENT:

Insured's Name: _____ Birthdate: _____

Insurance Name: _____

Insurance Address: _____

Certificate # or Member ID #: _____

Group #: _____

Secondary Insurance Coverage: _____

REASON FOR VISIT

❑ Illness ❑ Injury ❑ Job Related Injury ❑ Auto Accident

Date of Injury or Onset of Condition

Major Complaint

If applicable, explain how injury occurred.

How did you hear about us?

Who is your assigned Primary Care Physician?

How do you intend to pay? ❑ Cash ❑ Check ❑ Credit Card ❑ Insurance ❑ Medicare

AUTHORIZATION

(Please read before signing)

I request that all surgical or medical benefits, if any, otherwise payable to me for services rendered be paid to the provider of service. I understand that I remain financially responsible for all charges whether or not paid by insurance. I authorize the provider of service to release all information necessary to secure the payments of benefits. I also consent to the examination and/or treatment of myself and all minor children listed above by physicians, physician's assistants and other medical personnel. Failure to provide complete information may result in you receiving a bill for services.

Date: _____ Signed: _____ Staff Initials