

PLEASE PRINT CLEARLY

Patient # _____ Date: _____

PATIENT INFORMATION

Patient Name: (Last) _____ (First) _____ Middle Initial _____

Male Female DOB: _____ SSN: _____ Marital Status: _____

Address: _____ City, State, Zip: _____ County: _____

Home Phone: (____) _____ Alt Phone: (____) _____ Referring Doctor: _____

Employment: Full Time Part Time Self-Employed Not Employed Retired/Retire Date: _____

RESPONSIBLE PARTY

(If address is the same as patient, write SAME)

Name: (Last) _____ (First) _____ (MI) _____ DOB: _____

Phone: (____) _____ Address: _____

City, State, Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE

Carrier Name: _____ ID: _____ Group # _____

Subscriber Name: (Last) _____ (First) _____ (MI) _____

Male Female DOB: _____ SSN: _____ Relationship to Patient: _____

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State _____ Zip _____

SECONDARY INSURANCE

Carrier Name: _____ ID: _____ Group # _____

Subscriber Name: (Last) _____ (First) _____ (MI) _____

Male Female DOB: _____ SSN: _____ Relationship to Patient: _____

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State _____ Zip _____

I assign all insurance payments to The Huxford Clinic: Pulmonary and Sleep Medicine. I understand that any unpaid portion of charges for treatments not paid by my insurance company is my responsibility. I understand that if my balance is not paid in a timely manner and the account is referred for outside collections, I am responsible for any processing fees and/or court costs.

Signature: _____ Date: _____

EMERGENCY CONTACT

Name: (Last) _____ (First) _____ (MI) _____ DOB: _____

Phone: (____) _____ Address: _____

City, State, Zip: _____ Relationship to Patient: _____

PREFERRED PHARMACY

Pharmacy: _____ Address: _____

City, State, Zip: _____