Lung and Chest Medical Associates Patient Information Form

Chart#_____

Patient Name: _____

Mailing Address: _____
(City) (State) (Zip Code)

Address: (if different) _____
(City) (State) (Zip Code)

Date of Birth: _____-_____-_____ Age: _____ Sex: _____ Race: _____

Marital Status: Circle one: Single Married Widowed Divorced Legally Separated SS#: _____-_____-_____

Home phone #: (_____) _____-_____ Cell phone #: (_____) _____-_____

E-Mail Address: _____

Employer Name: _____Work Phone: _____

If a student, school name: _____Circle one: Full time or Part time

Ethnicity: Circle One American Hispanic Russian Other _____
Language: Circle One English Spanish Chinese Other_____

Are you, the patient, covered by spouse's/parent insurance? Circle one: Yes No
If other dependent. Circle one Child Step-Child Other ? _____
If yes, please complete the following information:
Spouse's/Parent's Name: _____Employer: _____
Spouse's/ Parent's SS #: _____-_____-_____ Date of Birth: _____-_____-_____

Family Physician _____
First Name Last Name Phone

Referring Physician (if different)_____
First Name Last Name Phone

Emergency Contact (Outside of your Household) _____
(Name) (Relationship) (Phone)

PRIMARY INSURANCE CARRIER: _____
SECONDARY INSURANCE CARRIER: _____

INSURANCE AUTHORIZATION

I request payment of authorized benefits be made on my behalf to Charles M. Fogarty, MD, PA, Wilson P. Smith, MD, PA, J. Douglas Clark, MD, PC, Rico Vicente I. Mendoza, MD, PA, Raul B. Cruz, MD, and/or Ikenna F. Onyebueke, MD PA for any healthcare services rendered to me by that physician. I authorize any holder of medical information about me to release to Health Care Financing Administration and/or my other insurance companies any information needed to determine benefits payable. I understand I am responsible for any amounts approved but not covered by my insurance.

CONSENT FOR TREATMENT

I understand that in signing the below I authorize and consent for treatment from the physicians of Lung and Chest Medical Associates, this also includes the disclosure of medical information between covered entities that will be involved in your healthcare treatment. Covered entities may include but not limited to your referring physician, labs, hospitals, insurance companies or in home medical equipment providers or nursing agencies that may also contribute to your care provided to you by Lung and Chest Medical Associates.

STATEMENT OF FINANACIAL RESPONSIBILITY

I understand that my insurance(s) may not cover the entire cost of all services received in this office; therefore, I recognize that ultimate financial responsibility for my account remains mine. I hereby guarantee payment in full of any and all charges for services rendered not covered by any health benefits plan, including all deductible and coinsurance amounts.

_____ _____

(Patient's Signature) **(Date)** **03/2016**