



PULMONARY CLINIC OF THE CAROLINAS, PC

New Patient Registration Form Personal Information

Please Print

Date ____/____/____

Patient's Name _____
Last First Middle

Date of Birth ____/____/____ Age ____ Patient's Social Security # ____-____-____

Sex: Male Female Marital Status: Married Single Widowed Other _____

Patient's Address: _____
Street Address City State Zip

Home Phone Number () _____-____ Work Phone Number () _____-____

Responsible Party's Name _____ Date of Birth ____/____/____

Responsible Party's SS# ____-____-____ Relationship to Patient _____

Responsible Party's Employer _____ Work # _____

Employer's Address _____
Street Address City State Zip

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

How did you learn of our clinic? _____

Preferred Method of Payment _____

In Case of Emergency Contact _____ Telephone # _____

I hereby consent to treatment for myself or the patient named herein for whom I am legally responsible. I hereby authorize the release of any medical information relating to me to the under mentioned care giver: _____ and/or Health Insurance Company necessary for processing insurance claims on my behalf and for direct payment of any medical/surgical benefits otherwise payable to me to Pulmonary Clinic of the Carolinas, PC for services rendered to me. I hereby acknowledge and accept financial responsibility for payment of all medical services provided me or rendered on my behalf.

Signed (Patient or Legal Guardian) _____/____/____ Date

Pulmonary Clinic of the Carolinas, PC

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