Tri-State Pulmonary Associates Patient Registration

DATE: _____ ***Circle One*****:** Scott_Orabella_Dama_Schmitt_Kanagarajan_Weinstein_Jiven_Lanka_Mulllins

Patient Name: _____ Date of Birth: _____ Sex (M / F)
(first) (middle) (last)

SSN# _____ - _____ - _____ Home phone (_____) - _____ - _____ Cell Phone (_____) _____- _____

Marital status: S M E-mail_____Address: _____

City: _____State: _____ Zip: _____

Employer: _____Work Phone: (____) - _____- _____

Emergency Contact Name: _____ Relationship: _____ Ph #: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance: _____ Policy/ID#: _____ Group #: _____

Effective date: _____ Patient Relationship to Policyholder: self __ spouse __ Child __ Other __

Name of Policyholder: _____ Date of birth: _____ Sex (M / F)

Employer Name: _____

Secondary Insurance: _____ Policy/ID#: _____ Group #: _____

Effective date: _____ Patient Relationship to Policyholder: self __ spouse __ Child __ Other __

Name of Policyholder: _____ Date of birth: _____Sex (M / F)

Employer Name: _____

Authorizations: I hereby assign all medical/surgical benefits to which I am entitled, including Medicare, private insurance and any other plan to Tri-State Pulmonary Associates, Inc. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am responsible for coninsurance/deductibles not payable by insurance. I hereby authorize Tri-State Pulmonary to release information requested by my insurance company to secure payment. I authorize payment directly to Tri-State Pulmonary Associates. I further authorize Tri-State Medical Associates, Inc. to render treatment and/or medical advice for myself and/or my dependent.

Notice of Privacy practices for Protect Health Information and Acknowledgement of Receipt of Notice: I acknowledge that I have received/declined a copy of Tri-State Pulmonary Associates, Inc. HIPAA Notice of Privacy Practices and understand that my protected health information may be used by the practice as stated in the notice.

I have read and understand the office policy statement above and agree to accept responsibility as described.

Patient Signature or Responsible Party:_____ Date:_____

Witness:_____Date:_____

A $30 FEE will be charged for NO-SHOW/Cancellations less than 24 hours, $25 returned check fee. registration 2.13.14 rev/dz