LAKE PULMONARY ASSOCIATES
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Practice of Pulmonary and Critical Care Medicine

Patient Information:

Patient Name____ ☐Jr. ☐Sr. **Minor?** ☐Yes ☐No
Last Name First Name Middle Initial

Address: ______________________________ City ___________________ State _____ Zip _________

Home Phone:__________________ Cell Phone: __________________ Work Phone: __________________

Email Address:_______________________________________ **Pharmacy**:______________________

Social Security Number:_____/_____/_____ **Date Of Birth:**_____/_____/_____ Sex: ☐Male ☐Female

Primary Language:________________________ **Referring Dr:**______________________________

Race: ☐Asian ☐African-American/Black ☐Caucasian ☐Hispanic ☐Native American/American Indian ☐Other

Ethnicity: ☐Not Hispanic ☐Mexican ☐Puerto Rican ☐ Cuban ☐Other____________________________

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Legally Separated ☐Partner ☐Other

Emergency Contact:

Emergency Contact_____________________________ Relationship To Patient:_____________________

Home Phone:__________________ Cell Phone: __________________ Work Phone: __________________

Insurance Information:

Primary Insurance:__________________________ **Secondary Insurance**:__________________________

ID:________________ Group #:________________ ID:________________ Group #:________________

Policy Holder's Name:________________________ Policy Holder's Name:________________________

Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Date of Birth: _____/_____/_____

Relationship of Patient to insured________________ Relationship of Patient to insured________________

I, the undersigned, authorized the release of any medical information necessary to process this claim for payment. I authorize payment be made by my insurance company to the above physician according to my contract. I understand I am responsible for non-covered services, deductibles, and co-payments.

Patient Signature____________________________________ **Date**____________________________

If minor/POA/Witness________________________________ **Date**____________________________