Pulmonary Associates of Southern Arizona
Patient Registration Form

Patient Id: ________________

Name: ________________________________ **DOB:** ____________ **Patient SSN:** ____________________

Address: ____ **Gender:** **Male** **Female**

City: ______________ **St:** ________ **Zip code:** ______________ **Marital Status:** ________________

Patient Race: American Indian/ Ak. Native Asian Black/ African American Pacific Islander Other White Declined

Patient Ethnicity: Hispanic Not Hispanic Declined Unknown Preferred Language**:** ________________

Home #: ______________________________ **Cell #:** ______________________________

Employer: ______________________________ **Work #:** ______________________________

Primary Care Physician: ________________________ **Email:** ______________________________

Preferred Pharmacy and Address: ____

Primary Insurance: ____________________________ **Policy Holder SSN:** ________________

Policy Holder: ____________________________ **Policy Holder DOB:** ________________

Policy Id #: ____________________________ **Group #:** ________________

Policy Holders Relationship: Daughter Son Spouse Other

Secondary Insurance: ____________________________ **Policy Holder SSN:** ________________

Policy Holder: ____________________________ **Policy Holder DOB:** ________________

Policy Id #: ____________________________ **Group #:** ________________

Policy Holders Relationship: Daughter Son Spouse Other

Emergency Contact: ____________________________ **ER. Contact Telephone #:** ________________

Emergency Contact Relationship to patient: ____

AUTHORIZED RECIPEINT OF HEALTH INFORMATION: ____
The persons named may receive information regarding my Healthcare. This authorization may be revoked or altered at your request. **Please include contact name and phone number.**

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ALL PATIENTS PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS: "I hear by authorized Pulmonary Associates of Southern Arizona to release to or request from my insurance company, other physicians or hospitals, any information including the diagnosis and records of any treatment or examination rendered to me during pulmonary care, and that this information may be faxed. I also authorized and request my insurance companies to pay directly to the above-named corporation the amount due me in my pending claim for medical treatment or service. I also understand that if it becomes necessary to refer my account for collection, I will be liable for the reasonable collection fees and court costs expended therein." **THE PHYSICIANS RESERVE THE RIGHT TO CHARGE INTEREST ON UNPAID ACCOUNTS. I ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF PASA'S PRIVACY NOTIFICATION.**

Signature: ______________________________________ **Date:** ____________________