Pulmonary, Critical Care and Sleep Medicine Specialists of SW Florida

PATIENT INFORMATION & TREATMENT CONSENT

Patient Name: _____ Birth Date: _____

Phone: Home _____ Cell_____ Work_____

Email: _____ Social Security Number: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Marital Status: S M W D

Spouse/Guardian: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

What language do you prefer to use to discuss your healthcare information? _____

Race: _____ Ethnicity: _____ Gender: □ Male □ Female

PHARMACY INFORMATION

Primary:
Pharmacy Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Other:
Pharmacy Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Insurance Company Name: _____ Is the patient retired?: Y N
Policy No.: _____ Group No.: _____ Effective Date: _____
Policy Holder's Name: _____ Birth Date _____ Relationship to Patient _____
Secondary Coverage? Y N
Insurance Company Name: _____ Policy No.: _____

TREATMENT CONSENT

The patient and/or authorized representative of the patient whose signature is affixed below does hereby consent to medical treatment which may be deemed advisable by my physician/provider. The intention, hereof, being to grant authority to administer and perform all examinations, treatment, and diagnostic procedures which may now or during the course of my care be deemed necessary.

Patient Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____