

## Patient Demographic &amp; Insurance Information

## Basic Patient Information

Patient's Social Security Number: \_\_\_\_\_

Name of Patient

First

Middle

Last

Birth Date

Gender

F

M

Mailing Address

City

State

Zip

Home Phone ( )

Cell Phone ( )

Work ( )

## Which Physician are you seeing today?

Physician:

DRO LOPEZ, MD

ANNE LIPSCOMB, MD

NELIUS SULLIVAN, MD

M DINESH CHANDRA, MD

RAYAN KRISHNAMURTHY, MD

ABIAN SALINAS, MD

IAMMAD AZAM, MD

**Please present your insurance card to the front desk receptionist when returning this form**

## Power of Attorney or Guarantor other than patient

Name of Insured

First

Middle

Last

Street Address

City

State

Zip

Birth Date

Guarantor's Social Security Number: \_\_\_\_\_

Gender

F

M

Home Phone ( )

Work Phone ( )

Guarantor's Employer

## Insurance Coverage - Primary

Name of Insurance

Policy or Contract Number

Effective Date: (if applicable)

Group Number

Primary Care Physician

Name of Insured

## Patient's Relationship to Insured?

Self

Child

Spouse

Guardian

Other

Birth Date

Retire Date (if applicable)

Gender

F

M

Phone ( )

Name of Insured's Employer

Address of Insurance Holder

(If different than Patient Address)

City

State

Zip

I hereby authorize all insurance payments, including Medicare, to be made directly to Tuscaloosa Lung & Sleep Consultants, PC for medical services rendered. I authorize the release of any medical information deemed necessary in the processing of a claim. I understand that I am responsible for any and all charges, regardless of insurance coverage. I also agree that failure to make payment when requested is the basis for legal action, and agree to pay all costs of collections, including reasonable collection fees. I authorize the physicians to perform any procedures which may be deemed necessary in the judgement of the attending physician in the diagnosis and treatment of the patient's condition.

Date

Signature



## Insurance Coverage - Secondary

Name of Insurance \_\_\_\_\_

Policy or Contract Number \_\_\_\_\_

Effective Date: \_\_\_\_\_

Group Number \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Name of Insured \_\_\_\_\_

First

Middle

Last

### Patient's Relationship to Insured?

Self

Child

Spouse

Guardian

Other

Birth Date \_\_\_\_\_

Retire Date (if applicable) \_\_\_\_\_

Gender

F

M

Phone ( ) \_\_\_\_\_

Name of Insured's Employer \_\_\_\_\_

Address of Insurance Holder \_\_\_\_\_

(If different from Patient Address) \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

### Additional Patient Information

Marital Status

Single

Married

Divorced

Separated

Widowed

Patient's Employment Status

Full-Time

Part-Time

None

Retired

Spouse's Employment Status

Full-Time

Part-Time

None

Retired

Student Status (If Applicable)

Full-Time

Part-Time

None

Preferred Pharmacy \_\_\_\_\_

LOCATION \_\_\_\_\_

Patient's Employer \_\_\_\_\_

ZIP CODE \_\_\_\_\_

Referring Physician \_\_\_\_\_

All other Physicians \_\_\_\_\_

### Emergency Contact Information - Primary Contact

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_