

Basic Patient Information

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

Name of Patient \_\_\_\_\_  
First Middle

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

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

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

Which Physician are you seeing today?

Physician:

DRO LOPEZ, MD  ANNE LIPSCOMB, MD

RAYAN KRISHNAMURTHY, MD  ABIAN SALINAS, MD

**Please present your insurance card to the front desk receive**

Power of Attorney or Guarantor other

Name of Insured \_\_\_\_\_  
First Middle

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

City \_\_\_\_\_ State \_\_\_\_\_

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

Gender F M

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

Guarantor's Employer

Insurance Coverage - Primary

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

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

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

Primary Care Physician \_\_\_\_\_

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

Patient's Relationship to Insured?

Self  Child  Spouse

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

Gender F M

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

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

(If different than Patient Address)

City \_\_\_\_\_

I hereby authorize all insurance payments, including Medicare, to be made directly to Tuscaloosa Lung & Sleep Consultants, PC for medical services rendered 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 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 - Second**

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

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

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

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

First

**Patient's Relationship to Insured?**

Self

Child

Spouse

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

Gender

F

M

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

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

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

City \_\_\_\_\_

**Additional Patient Information**

Marital Status

Single

Married

Patient's Employment Status

Employed

Unemployed -Time

Spouse's Employment Status

Employed

Unemployed -Time

Student Status (If Applicable)

Student

Not a Student -Time

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

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

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

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

**Emergency Contact Information - Print**

Name \_\_\_\_\_

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

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

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

City \_\_\_\_\_

State \_\_\_\_\_





**Primary**

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

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

Middle

Last

Guardian

Other

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

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

State \_\_\_\_\_

Zip \_\_\_\_\_

**Person**

Divorced

Separated

Widowed

Widowed

Retired

Widowed

Retired

Widowed

LOCATION \_\_\_\_\_

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

**Secondary Contact**

Relationship \_\_\_\_\_

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

Zip \_\_\_\_\_