West Coast Pulmonary Critical Care Physicians, Inc.

Sunset Sleep Disorder Center of Oxnard

PATIENT INFORMATION PLEASE PRINT

Today's Date _____ **Referred By** _____

Name_____
Last First M.I.

Address_____

City_____ Zip_____

Birth Date _____Phone #_____

Age_____Cell Phone #_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Child

Social Security Number _____

Employer_____

Employer's Address_____

Business Phone #_____

Occupation _____

Responsible Party (if other than patient)

_____

Name of Spouse _____

Social Security Number _____

Date of Birth _____

Spouse's Employer_____

Employer's Address _____

Business Phone # _____

Cell Phone #_____

Occupation _____

Person to notify in case of emergency other than spouse:

_____

Relationship _____

Address _____

Phone # _____

INSURANCE INFORMATION (copies of card(s) required)

PRIMARY INSURANCE

Insurance Company _____

I.P.A./Medical Group _____

Insured's Name_____

Insured's I.D. # _____

Group #_____

SECONDARY INSURANCE

Insurance Company_____

I.P.A./Medical Group _____

Insured's Name _____

Insured's I.D. # _____

Group # _____

AUTHORIZATION OF BENEFITS TO PHYSICIANS:
I hereby autorize payment directly to West Coast Pulmonary Critical Care Physicians, Inc. of the surgical and/or medical benefits, if any, otherwise payable to me for the services as described on the attached claim.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize West Coast Pulmonary Critical Care Physicians, Inc. to release any information acquired in the course of my examination or treatment.

_____ _____
SIGNED (INSURED PERSON) DATE