WEST COAST PULMONARY
& SLEEP DISORDERS CENTER

Patient Information

Today's Date: _____ Referred by: _____

Name: _____ Last	_____ First	_ M.I.	*Spouse information* Name of spouse:
Address:			Social Security Number:
City:	**State:**	ZIP:	Date of birth (m/d/yy):
Birth Date:	Phone #:		Spouse's employer:
Age:	Cell phone #:		Employer's address:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Child			Business phone:
Social Security Number:			Cell phone #:
Employer:			Occupation:
Employer's address:			**Person to notify in case of emergency other than spouse:**
Business phone #:			
Occupation:			Relationship:
Responsible Party (if other than patient):			Address:
			Phone #:

Insurance Information (copies of card(s) required)

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
I.P.A./Medical Group:	I.P.A./Medical Group:
Insured's Name:	Insured's Name:
Insured's I.D. Number:	Insured's I.D. Number:
Group #:	Group #:

Authorization of Benefits to Physicians

I hereby authorize payment directly to West Coast Pulmonary 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 Physician, Inc. to release any information acquired in the course of my examination or treatment.

_____ _____

Signed (insured person) Date (m/d/yy)