SOUTH BAY RESPIRATORY ASSOCIATES
PATIENT REGISTRATION INFORMATION

PATIENT'S PERSONAL INFORMATION

Last Name_____ First Name_____ Middle Initial_____

Street Address_____City_____State_____Zip_____

Male_____ Female_____ Social Security #_____ - _____- _____

Home Phone (_____)_____ Cell Phone (_____)_____ Date of Birth_____/_____/_____

Employer_____Work Phone (_____)_____

RESPONSIBLE PARTY INFORMATION

(If different from patient information)

Relationship to Patient: Spouse_____ Parent_____Other_____

Last Name_____ First Name_____ Middle Initial_____

Street Address_____City_____State_____Zip_____

Male_____ Female_____ Social Security #_____ - _____- _____

Home Phone (_____)_____ Cell Phone (_____)_____ Date of Birth_____/_____/_____

Employer_____Work Phone (_____)_____

MEDICAL INSURANCE INFORMATION

Insurance Company_____ Subscriber Name_____

Insurance ID #_____ Group #_____

Secondary Insurance_____ Subscriber Name_____

Insurance ID #_____ Group #_____

WORKERS COMPENSATION INFORMATION

Insurance Carrier Name_____

Street Address_____City_____State_____Zip_____

Adjuster Name_____ Contact Phone (_____)_____

Date of Injury_____ Case #_____

REFERRAL INFORMATION

Name of Referring Physician_____ OR Self Referred_____

Name(s) of other physician(s) who care for you_____

EMERGENCY CONTACT

Name_____Phone #_____

ASSIGNMENT OF BENEFITS

I hereby give lifetime authorization for payment of insurance benefits to be made directly to South Bay Respiratory Associates for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize South Bay Respiratory Associates to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

PATIENT'S SIGNATURE_____DATE_____