Pulmonary and Critical Care
Specialists of Princeton, PC

Patient Information:

Patient Name (last, first, middle): _____ DOB: _____
Street Address: _____ City: _____St: ___ Zip: _____
Male: ___ Female: ____ Social Security Number: _____
Email Address: _____
Phone Number: _____ Cell Number: _____
Marital Status: Married: __ Single: __ Widowed: __ Divorced: _
Separated: __
Employers Name: _____
Employers Address: _____ Employers Phone Number: _____

Insurance Information:

Primary Carrier: _____ Address: _____
Contact Number: _____ Group Number: _____
Secondary Carrier: _____ Address: _____
Contract Number: _____ Group Number: _____

Responsible Party:

Responsible Name: _____ DOB: _____ Relationship to Pt: _____

Emergency Contact: (other than responsible party)

Name: _____ Phone Number: _____
Relationship to Patient: _____

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Address: _____
Pharmacy Phone Number: _____
Mail Order Company: _____ Phone Number: _____
DME Company: _____ Phone Number: _____

I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance, in the opinion of Pulmonary and Critical Care Specialist of Princeton, PC and or for assisting in any reimbursement or medical benefits to which patient may be entitled. I allow fax transmittal of my records if necessary. I further authorize and request that insurance payment be made directly to Pulmonary and Critical Care Specialists of Princeton, PC should they elect to receive such payment. This s a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by Pulmonary and Critical Care Specialist of Princeton, PC in understand that payment of charges incurred is due at the time of services unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by Pulmonary and Critical Care Specialist of Princeton, PC physicians and personnel.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization. This authorization is valid for six months.

Signature: _____ Date: ____/___/_____