## **SOUTH BAY RESPIRATORY ASSOCIATES** PATIENT REGISTRATION INFORMATION

## PATIENT'S PERSONAL INFORMATION

| Last Name                                         | First Name        |                 | Middle Initial    |  |
|---------------------------------------------------|-------------------|-----------------|-------------------|--|
| Street Address                                    |                   | City            | StateZip          |  |
| Male Female                                       | Social Security # |                 |                   |  |
| Home Phone ()_                                    | Cell Phone (      | )               | Date of Birth / / |  |
| Employer                                          |                   |                 | Work Phone ()     |  |
| RESPONSIBLE PARTY INFORM                          | (If differen      | nt from patient |                   |  |
| Relationship to Patient: Spouse                   | Parent            | Oth             | er                |  |
| Last Name                                         | First Nar         | ne              | Middle Initial    |  |
| Street Address                                    |                   | _City           | StateZip          |  |
| Male Female                                       | Social Security # |                 |                   |  |
| Home Phone ()                                     | Cell Phone (      | )               | Date of Birth/    |  |
| Employer                                          | Work Phone ()     |                 |                   |  |
| MEDICAL INSURANCE INFORM                          | ATION             |                 |                   |  |
| Insurance Company                                 |                   | Subscri         | iber Name         |  |
| Insurance ID #                                    |                   | Group :         | #                 |  |
| Secondary Insurance                               |                   | Subscr          | iber Name         |  |
| Insurance ID #                                    |                   |                 |                   |  |
| WODE FOR COMPENSATION IN                          |                   |                 |                   |  |
| WORKERS COMPENSATION INI Insurance Carrier Name   | ORMATION          |                 |                   |  |
|                                                   |                   | City            | StateZip          |  |
| Adjuster Name                                     |                   |                 | Contact Phone ()  |  |
| Date of Injury                                    |                   |                 | Contact I none (  |  |
| Date of injury                                    |                   | ase #           |                   |  |
| REFERRAL INFORMATION  Name of Referring Physician |                   |                 | OR Self Referred  |  |
|                                                   |                   |                 |                   |  |
|                                                   | ne                |                 | Phone #Phone #    |  |

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\_