SANTA BARBARA PULMONARY CONSULTANTS

PATIENT REGISTRATION

(Please PRINT)

NAME:____
(Last) (First) (Middle)

MAILING ADDRESS:____

STREET ADDRESS:____

CITY:______________________________ STATE:_______ ZIP CODE:________________

HOME PHONE:__________________________ GENDER: (circle one) MALE FEMALE

WORK PHONE:__________________________ BIRTHDATE:____/___/_____ AGE:__________

CELL PHONE:__________________________ SOCIAL SECURITY #:____________________

EMPLOYER:____

EMPLOYER ADDRESS:____

MARITAL STATUS: (circle one) S M W D SPOUSE'S WORK PHONE:___________________

SPOUSE'S NAME:_________________________ SPOUSE'S CELL PHONE:___________________

EMERGENCY CONTACT:__________________________ PHONE:_________________________

RESPONSIBLE PARTY:_________________________ RELATIONSHIP TO PATIENT:________________

REFERRING / PRIMARY CARE PHYSICIAN:_______________________________________

OTHER
PHYSICIANS:____

____

INSURANCE INFORMATION:
PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST

Financial Policy:

I hereby authorize treatment by Drs. Kupperman, Ungerer, Wright, Belkin and Sager and understand that I am financially responsible for all fees and charges for such treatment whether or not they are covered by my insurance policy. I understand Drs. Kupperman, Ungerer, Wright, Belkin and Sager are contracted with some, but not all, insurance plans and it is my responsibility to be aware of the terms and limitations of my insurance coverage. If my insurance policy is through an HMO I understand it is my responsibility to ensure that authorization has been obtained from my primary care physician **prior** to receiving services from Drs. Kupperman, Ungerer, Wright, Belkin and Sager. If such authorization has not been given, I understand that I will be financially responsible for all fees and charges.

I understand that during the course of my office visit with Drs. Kupperman, Ungerer, Wright, Belkin and Sager it may be necessary for him to perform additional diagnostic or therapeutic services at his discretion. I understand that charges for these services will be in addition to the regular office charges.

I authorize Drs. Kupperman, Ungerer, Wright, Belkin and Sager to furnish any medical information necessary to process my claim to my insurance carrier and to other physicians, hospitals, and health care facilities and hereby irrevocably assign to the doctor payment for all medical services and unpaid balances. I authorize copies of this authorization to be used in place of the original. If my account is referred to an attorney or collection agency, I agree to pay reasonable fees and collection expenses.

This authorization will remain in effect until revoked by me in writing.

SIGNED:____ DATE:________________