☐ Allan R. Goldstein, M.D.
☐ Russell G. Beaty, M.D.
☐ W. Bishop Kelley, M.D.

PULMONARY ASSOCIATES OF THE SOUTHEAST, P.C.

☐ Sandra Gilley, M.D.
☐ Alan Q. Thomas, M.D.

PATIENT INFORMATION

Referred By:_____

Account #:_____

SSN: _____ Drivers License #:_____

Patient Name: Last: _____ First: _____ Middle:_____

Address:_____

City: _____ State: _____ Zip: _____ Phone:(___)_____

Email Address: _____ ☐ Male ☐ Female Birthdate: _____ Marital Status: _____

☐ Employed Full time ☐ Employed Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military Duty ☐ Unknown

☐ Full Time Student ☐ Part Time Student ☐ Not a Student Cell # _____

Employer:_____ Phone: (___)_____

Person Responsible for Account: _____ Relationship: _____

Address:_____

City: _____ State: _____ Zip: _____ Phone:(___)_____

Employer:_____ Phone: (___)_____

Person to notify in case of emergency: # outside home _____ Phone: (___)_____

Have you arranged for a Living Will? (Advance Directives) ☐ Yes ☐ No Have you appointed a durable power of attorney? ☐ Yes ☐ No

INSURANCE POLICY INFORMATION

Insurance Company (Primary):_____

Policy Holder's Name: _____ Birthdate:_____

Employer:_____

Contract or Group:_____

Relationship of patient to policy holder:_____

Insurance Company (Secondary):_____

Policy Holder's Name: _____ Birthdate:_____

Employer:_____

Contract or Group:_____

Relationship of patient to policy holder _____

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff. ____Initial *

I (aka) authorize Pulmonary Associates to utilize the medical information obtained during the course of my treatment in medical research and education programs as long as my name & likeness are not revealed and my privacy is completely protected. ____ Initial *

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize the release of any and all my treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers. This includes psychological or psychiatric care, attention and treatment. ____ Initial *

ASSIGNMENT - I hereby assign Pulmonary Associates of the Southeast, P.C. all payments for medical and/or surgical services rendered to me or my dependents due or received from third-party providers. I agree to be responsible for any amount not covered by insurance or other providers. I agree to pay all costs of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection). ____ Initial *

SIGNATURE:_____ DATE:_____
(PATIENT, or PERSON RESPONSIBLE FOR ACCOUNT.)