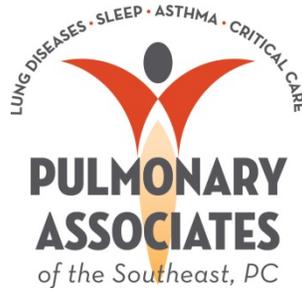


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Allan R. Goldstein M.D. • Erin M. Ozgun M.D. • Alan Q. Thomas M.D.**

PATIENT INFORMATION

Scheduled Physician _____ Referring Physician _____ Preferred Pharmacy _____
Last Name _____ First Name _____ Middle _____
DOB _____ Sex _____ SSN _____
Marital Status _____ Driver License # _____
Address _____
ZIP _____ City _____ State _____ County _____ Country _____
Home Phone _____ Work _____ Cell _____
Fax _____ Pager _____ Email _____
Preferred Communication _____

EMPLOYER

Name _____ Status _____
Occupation _____ Phone (w/extension) _____

ASSOCIATED PARTY (POLICY HOLDER)

Name _____ Type _____
Relationship _____ DOB _____

EMERGENCY CONTACT AND AUTHORIZED CONTACT

Emergency Contact Name _____ Phone Number _____
Authorized Contact Name & Number for Personal Health/Billing _____
Authorized 1. _____ Authorized 2. _____
Authorized 3. _____ Authorized 4. _____

INSURANCE

Do you have insurance coverage? Yes No
 Employer Exchange Individual Worker's Compensation
Insurance Cards Provided? Yes No

I HAVE READ THE ABOVE AND AGREE THAT THE INFORMATION IS CORRECT.

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

I (aka) authorize Pulmonary Associates of the SE 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. _____

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. _____

ASSIGNMENT – I hereby assign Pulmonary Associates of the SE, P.C. all payments for medical and/or surgical services rendered to 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 cost of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection). _____

Signature _____

Date _____