CITRUS PULMONARY CONSULTANTS AND SLEEP DISORDERS CENTER
WELCOME SHEET

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name:	First:		Maiden Name:		
Marital Status:	Social Security no.:	Birth date:	Age:	Sex: ○ M ○ F	Race/Ethnicity:
Email Address:					Language:
Mailing Address:		Home phone no.:		Cell phone no.:	
		Employer:		Employer phone no.:	
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Primary Insurance					
Insurance Name/Address:		Policy No:		Group No:	
Secondary Insurance					
Insurance Name/Address:		Policy No:		Group no.:	
Subscriber Name (if not the patient):					
Social Security no.:		Birth date:		Relationship to patient:	
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:		Work phone no.:

INSURANCE AUTHORIZATION

I authorize Citrus Pulmonary Consultants and Sleep Disorders Center to release any information, including diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Citrus Pulmonary Consultants and Sleep Disorders Center benefits otherwise payable to me. I understand that Citrus Pulmonary Consultants and Sleep Disorders Center will file to my insurance as a courtesy. I understand that my insurance carrier may pay less than those charges submitted. I agree to be held responsible for payment of all services rendered on my behalf. I understand that the amounts not paid are subject to further action.

_____ _____

Patient/Guardian signature **Date**

Please complete the following pages. Some of these pages are double-sided. If you need assistance, please notify the front desk.