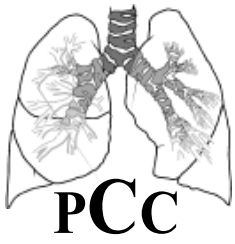

PULMONARY CLINIC OF THE CAROLINAS, PC

New Patient Registration Form
Personal Information

Please Print

Date _____/_____/_____

Patient's Name _____
Last First Middle

Date of Birth_____/_____/_____ Age _____ Patient's Social Security # _____-_____-_____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Other_____

Patient's Address: _____
Street Address City State Zip

Home Phone Number ( )_____-_____ Work Phone Number ( )_____-_____

Responsible Party's Name_____ Date of Birth _____/_____/_____

Responsible Party's SS# _____-_____-_____ Relationship to Patient _____

Responsible Party's Employer_____ Work # _____

Employer's Address _____
Street Address City State Zip

Primary Insurance_____ Policy # _____

Secondary Insurance_____ Policy # _____

How did you learn of our clinic? _____

Preferred Method of Payment _____

In Case of Emergency Contact_____Telephone # _____

I hereby consent to treatment for myself or the patient named herein for whom I am legally responsible. I hereby authorize the release of any medical information relating to me to the under mentioned care giver:_____ and/or Health Insurance Company necessary for processing insurance claims on my behalf and for direct payment of any medical/surgical benefits otherwise payable to me to Pulmonary Clinic of the Carolinas, PC for services rendered to me. I hereby acknowledge and accept financial responsibility for payment of all medical services provided me or rendered on my behalf.

_____ _____/_____/_____
Signed (Patient or Legal Guardian) Date

Pulmonary Clinic of the Carolinas, PC
442 E. Long Avenue, Gastonia, North Carolina 28054 • 704.867.8742 • FAX 704.867.8891
206 Gamble Drive, Suite D, Lincolnton, North Carolina 28092 • 704.736.9959 • FAX 704.736.9466