



6709 S. Minnesota Ave. Ste 205
 Sioux Falls, SD 57108
 605-271-1020
 605-271-2277 fax

ACCOUNT # _____

PATIENT INFORMATION

PLEASE PRINT

NAME: _____ BIRTHDATE: _____
Last First Middle

HOME ADDRESS: _____ PHONE: _____
Street City State Zip

EMPLOYER: _____ WORK PHONE: (____) _____ SOCIAL SECURITY #: _____

SEX: MALE FEMALE MARITAL STATUS: S WID DIV. M PATIENT E-MAIL: _____
Circle One

AN EMERGENCY CONTACT, OUTSIDE YOUR HOUSEHOLD: Relationship: _____

Name	Address	Phone
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SPOUSE'S NAME: _____ BIRTH DATE: _____
Last First Middle

EMPLOYER: _____ WORK PHONE: _____ SOC. SEC. NO.: _____

RESPONSIBLE PARTY: (If other than patient) SOC. SEC. NO.: _____

NAME: _____ SEX: M F BIRTHDATE: _____
Last First Middle Circle One

RELATIONSHIP TO PATIENT: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____ EMPLOYER: _____
Street City State Zip

PRIMARY INSURANCE COVERAGE

POLICY #: _____

DO YOU HAVE INSURANCE? YES NO

COVERAGE EFFECTIVE DATE: _____

PRIMARY INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

COVERAGE EFFECTIVE DATE: _____

POLICYHOLDER NAME: _____

POLICYHOLDER SS#: _____

POLICYHOLDER DOB: _____

POLICYHOLDER RELATIONSHIP TO PATIENT: _____

MEDICARE NUMBER: _____

EFFECTIVE DATE: _____

MEDICAID NUMBER: _____

EFFECTIVE DATE: _____

SUPPLEMENTAL/SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY NAME: _____

POLICYHOLDER SS#: _____

INSURANCE CO. ADDRESS: _____

POLICYHOLDER DOB: _____

POLICYHOLDER NAME: _____

POLICYHOLDER RELATIONSHIP TO PATIENT: _____

POLICY#: _____

POLICYHOLDER EMPLOYER: _____

AUTHORIZATION FOR TREATMENT: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic procedures and medical treatment by my physician, his assistants, or his designees including consulting physicians, employees, and students in educational programs affiliated with Pulmonary & Sleep Consultants, as is necessary in the judgement of my physician. I consent to testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

RELEASE OF INFORMATION: I hereby authorize Pulmonary & Sleep Consultants to release diagnostic and procedural information for the completion of insurance claim forms. I authorize the release of clinical information to third party payors and/or their reviewing contractors to comply with preadmission review and continued stay requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to Pulmonary & Sleep Consultants for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

 Patient Signature

 Patient's Representative

 Date

 Relationship to Patient