

Welcome to North Suburban Pulmonary and Critical Care Consultants, SC

PLEASE ASSIST US IN ACCURATELY REGISTERING YOU AND BILLING YOUR INSURANCE COMPANY

PATIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Phone #: () _____ Cell #: () _____

Birthdate: Month _____ Day _____ Year _____ Sex (Circle) M F

Social Security #: _____ - _____ - _____ Marital Status: (Circle) S M D W

PATIENT'S EMPLOYER

Employer Name: _____ (Circle) FT PT Retired Student

Address: _____

Phone #: () _____ Ext. _____

RESPONSIBLE PARTY/GUARANTOR OF ACCOUNT: PARENT, GUARDIAN OR PERSON RESPONSIBLE FOR PAYMENT (IF SELF LEAVE SELECTION BLANK AND GO TO NEXT SECTION)

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Phone #: () _____ Cell #: () _____

Birthdate: Month _____ Day _____ Year _____ Sex (Circle) M F

Social Security #: _____ - _____ - _____ Marital Status: (Circle) S M D W

Employer Name: _____ (Circle) FT PT Retired Student

Address: _____

Phone #: () _____ Ext. _____

REFERRING PHYSICIAN OR PRIMARY DOCTOR

Last Name: _____

Address: _____ Apt/Ste# _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Last Name: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Phone #: () _____ Cell #: () _____

I HEREBY AUTHORIZE NORTH SUBURBAN PULMONARY AND CRITICAL CARE CONSULTANTS, S.C. AND ITS AGENTS TO RELEASE TO, AND DISCUSS WITH MY INSURANCE COMPANY, FAMILY PHYSICIAN ANY INFORMATION TO TREATMENT BY NORTH SUBURBAN PULMONARY AND CRITICAL CARE CONSULTANTS, S.C. I AUTHORIZE THAT BENEFITS BE PAID DIRECTLY TO THEM. I UNDERSTAND THAT PAYMENT OF CHARGES IS NOT CONTINGENT ON ANY INSURANCE PAYMENT FROM MY INSURANCE COMPANY, AND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY UNPAID BALANCE.

Signature of Patient: _____ Date: _____