New Patient Registration

General Information

Last Name: ______________________________________, First Name: ______________________________

Date of Birth: ___________________________________ Social Security #: __________________________

Primary Address: ____

City: _____________________________________ State: _________________ Zip Code:__________________

Home Phone: (_______) ______________________ Cell Phone (______) ____________________________

Email Address: ____

Emergency Contact

Name: ____ Phone: (_____) ________________

Relationship: __________________________

Insurance Information

- **Primary Insurance Name**: ____

Insurance ID #: ___________________________________ Group #: __________________________

Relationship to Patient: ☐ Self ☐ Spouse Insured Name: _________________________________

- **Secondary Insurance Name**: ____

Insurance ID #: ___________________________________ Group #: ___________________________

Relationship to Patient: ☐ Self ☐ Spouse Insured Name: _________________________________

Electronic Communication Consent

Critical Care & Pulmonary Consultants would like to send you electronic communications via text, email, or voicemail message.

- Leave a detailed message on voicemail/machine/cell? ☐ Yes ☐ No Initials ________
- Send appointment reminder via text messaging? ☐ Yes ☐ No Initials ________
- Send appointment reminder to your email address? ☐ Yes ☐ No Initials ________

Sharing of Medical Information

I give Critical Care & Pulmonary Consultants permission to discuss my medical condition with the following individuals:

- Name: ____ Relationship:____________________________
- Name: ____ Relationship:____________________________
- Name: ____ Relationship:____________________________

Patient Signature: __________________________________ Date: _________________________