MEMORIAL PULMONOLOGY

10837 Katy Freeway, Suite 100
Houston, TX 77079
Tel (832) 325-1200
Fax (713) 984-8260

Registration Form

Today's Date:	Primary Care Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
☐ Yes ☐ No					☐ M ☐ F

Street address:	Social Security no.:	Home phone.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Internet	☐ Other

Other family members seen here:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance name:

Subscriber's Name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Please indicate your Pharmacy's Name and telephone number (if applicable):	( ) -
Please indicate your Home Health Agency's Name and telephone number (if applicable):	( ) -

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Mobile phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Memorial Pulmonology, P.A. and Dr. Krasko** or insurance company to release any information required to process my claims.

X

Patient/Guardian signature *Date*

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