# Suffolk Pulmonary Associates

60 North Country Road, Suite 203
Port Jefferson, New York 11777

Patient Name: _____

Date Of Birth: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____

Cell Phone: _____Marital Status: _____ Spouse Name: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Patient's Employer Name: _____ Phone: _____

Referring Doctor: _____ Primary Care Doctor: _____

Medicare #: _____ Medicaid #: _____

Other Insurance: _____ ID# _____Group # _____

Guarantor Employer: _____Guarantor Date of Birth: _____

Guarantor Social Security # _____ Relationship to Patient: _____

Other Insurance: _____ ID# _____ Group # _____

Guarantor Employer: _____Guarantor Date of Birth: _____

Guarantor Social Security # _____ Relationship to Patient: _____

Chest X-Ray/CT Scan/PET Scan (Location and Date) _____

I request that payment of authorized Medicare/Medicaid/Insurance Company benefits be made on my behalf to Suffolk Pulmonary Associates for services furnished to me by the provider. I also authorize Suffolk Pulmonary Associates to release medical information about me to Medicare/Medicaid/Insurance Company which is necessary to determine benefits payable to them. I also grant permission for this statement to be kept on file and used in place of my signature for submission of Medicare/Medicaid/Insurance Company claims.

Signature _____ Date: _____