PATIENT FINANCIAL INFORMATION

Name			
Social Security No.	Date of Birth	☐ Male ☐ Female	
Home Address	City	State	Zip Code
Home Phone No.	Cell Phone No.	Email	
Race	Language Spoken		
Employer		Phone No.	
Employer Address	City	State	Zip Code
Referring Physician		Phone No.	
Emergency Contact (Not Living With You)		Phone No.	
Pharmacy	Address	Phone No.	

INSURANCE INFORMATION – **Please give cards to staff so copies can be made for our files.**

PRIMARY POLICY (Circle One):	Blue Shield	Medicare	HMO	Commercial	Other
Primary Policy No.				Group No.	
Insurance Company Name	Address			Phone No.	
Guarantor				Birth Date	
SECONDARY POLICY (Circle One):	Blue Shield	Medicare	HMO	Commercial	Other
Secondary Policy No.				Group No.	
Insurance Company Name	Address			Phone No.	
Guarantor				Birth Date	

I authorize the release of any medical information necessary for my treatment and to process claims as well as authorization of payment directly to Pulmonary and Critical Care Associates of Baltimore, PA. I understand that I am responsible to know if my insurance requires a referral and for obtaining a referral from my primary care physician. I am financially responsible for all co-pays and charges not covered by insurance. I also hereby acknowledge that I have received/reviewed a copy of PCCAB's Notice of Privacy Practices.

Signature	Date
Verified By	Date