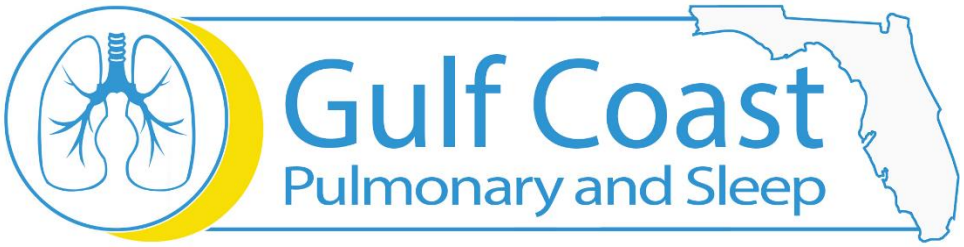


5857 21st Avenue West Suite A Bradenton, FL 34209

Phone: 941-792-0611 Fax: 941-792-0086

Date: _____

Name: _____ DOB: _____

SSN: _____ Gender: F / M/Other Marital Status: M / S / W / Other

Race: White / Black / Hispanic / Asian / American Indian / Other

Ethnicity: Hispanic / non-Hispanic Language: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Out of state address_____

Email Address : _____

Referring Physician: _____Primary Care Physician: _____

Pharmacy Name Phone # /
Address:_____

Gulf Coast Pulmonary and Sleep is authorized to obtain information from my pharmacy for continuation of my medical care

Emergency Contact Name and Phone#: _____
Relationship: _____

Person(s) Authorized to receive Medical Information/make decisions on my behalf:

_____

_____

Insurance Information:

Primary Ins: _____ Policy #:_____

Secondary Ins : _____ Policy #:_____

**Authorization to obtain or release medical records from medical providers**: I authorize Gulf Coast Pulmonary and Sleep to obtain any medical records concerning my care from any physician, hospital, or other health care professionals. I also authorize Gulf Coast Pulmonary and Sleep to release any medical records concerning my care to any health care professionals, insurance companies, third party administrators, or managed care company.

**Please provider your insurance card and drivers license so we can make a copy for your file**. Payment is expected at the time of service. The patient is responsible for any deductible, co payment and any amount not covered by their insurance policy. **Assignment and Release**: I certify that I and/or my dependents have insurance coverage with the above insurance company (ies) and assign directly to Gulf Coast Pulmonary and Sleep all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature for all insurance submissions. I have been shown the notice of privacy practices and have been provided the opportunity to review it.

The above named physician may use my health care information and may disclose such info to the above named insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed below, I hereby authorize said assignee to release all information necessary to secure payment. I authorize Gulf Coast Pulmonary and Sleep to download my medication history and RX benefits into my account from a RX clearing house.

Signature: _____ Date:_____

Relationship if not patient _____