SHORE PULMONARY, P.A.

301 Bingham Avenue Suite B
Ocean, New Jersey 07712

2640 Highway 70, Bldg. 6, Unit-A
Manasquan, New Jersey 08736

1608 Rte 88, Ste 117
Brick, NJ 08724

Patient Information Sheet

* I was referred to you by: _____

Patient Information

Last Name | **First Name** | **Middle**

Maiden Name | **Prefix** (Mr. Ms. Mrs. Miss) | **Age** | **Date of Birth** | **Sex** (Male Female) | **Social Security#**

Marital Status (Married Separated Widowed Single) | **Drivers License#** | **Race** | **Ethnicity**

Language Spoken

Address Information

Street Address | **City/State/Zip** | **County**

Phone Numbers

Home | **Work/Ext** | **Cell**

Email Address

Other Information

Employer Name/Address | **Phone/Ext**

Emergency Contact | **Relation** | **Phone** | **Is this the policy holder on the insurance?** (No Yes)

Pharmacy Name | **Pharmacy Phone** | **Pharmacy Fax**

Name of Referring Physician | **Name of Primary Care Physician**

Insurance Information (Please provide a copy of your driver's license and insurance card at the time of check-in.

Primary Insurance Carrier

Insurance Company | **Policy Holder** | **Policy Number** | **Group Number**

Policy Holder's address (if not patient) | **City/State/Zip** | **DOB** | **SSN**

Secondary Insurance Carrier

Insurance Company | **Policy Holder** | **Policy Number** | **Group Number**

Policy Holder's address (if not patient) | **City/State/Zip** | **DOB** | **SSN**

☐ ***If Patient Is a Medicare Recipient:***
I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services (CMS) or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize this office to furnish my insurance carriers with any information relevant to my claim, and to make direct payment when accepted.

☐ ***If Patient is Covered by Health Insurance:***
I request all payments be made to this doctor directly for covered services. I agree to pay any amount the insurance company did not or will not pay.

☐ ***Medigap Waiver:***
I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to my Medigap insurance any information needed to determine these benefits payable for related services.

Medigap Insurance_____ HIC#_____

PATIENT SIGNATURE:_____ DATE:_____