Cisca Pulmonary and Critical Care

Alexis A. Vazquez, D.O.

PATIENT DEMOGRAPHICS

Name (First, Middle, Last): _____

Date of Birth: _____ Gender: M F Social Security Number: _____

Marital Status: S M D W Height: _____ Weight: _____

Email: _____

Street Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

Employer: _____

Emergency Contact Information

Contact Name: _____ Relationship to Patient: _____

Phone Number(s): _____

Complete Address: _____

Physician Information

Primary Care Physician: _____ Phone: _____

Address: _____

Who referred you to our practice? _____

Phone: _____ Address: _____

Insurance Information

PRIMARY Insurance Company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

SECONDARY Insurance Company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

I hereby authorize my insurance benefits to be paid directly to Cisca Pulmonary and Critical Care. I understand I am responsible for all charges, including costs incurred due to any effort to collect for services rendered. **I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information required to file for medical benefits.**

Signature of Responsible Party: _____ Date: _____