Pulmonary and Critical Care Associates, P.C.

REGISTRATION INFORMATION

(PLEASE PRINT)

Date:	Name of PCCA Provider You Are Seeing:		
PATIENT INFORMATION			
Patient's Last Name	First	Middle	Preferred Pharmacy (Name/Phone number)
Birth Date:	Sex: ❑ Male ❑ Female	Soc. Sec. #:	
Race: ❑ African American ❑ Asian ❑ Native American ❑ White ❑ Other	Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino	Marital Status: ❑ Single ❑ Married ❑ Domestic Partner ❑ Divorced ❑ Widowed	
Street Address:	City:	State:	Zip:
Home Phone No.: ( )	Cell Phone No.: ( )	Other Phone No. (please identify): ( )	
Contact E-Mail Address:	Preferred Communication: ❑ E-mail ❑ Patient Portal ❑ Phone (*please select: cell, home or other*)		
Referred by:	Primary Care Physician:		
IN CASE OF EMERGENCY			
Person to be notified in case of emergency:	Phone No.:		
INSURANCE INFORMATION			
Do you have medical insurance? ❑ Yes ❑ No *(If yes, please complete the following section)*			
Spouse (or Responsible Party):	Soc. Sec. # of Spouse (Responsible Party)		
Name of Primary Insurance:			
Policy Holder's Name:	Policy Holder's Birth Date:		
Name of Secondary Insurance *(if any):*			
Policy Holder's Name:	Policy Holder's Birth Date:		

*****PLEASE HAND INSURANCE CARDS AND DRIVER'S LICENSE TO RECEPTIONIST WITH COMPLETED FORM*****