Pulmonary & Sleep Consultants, LLC
Serenity Sleep Institute
689 Medical Park Drive, Suite 204
Lenoir City, TN 37772
Phone (865) 986-9151 Fax (865) 986-9153

"Breathe Easier, Sleep Better"

PATIENT INFORMATION

PATIENT'S FIRST NAME	MI	LAST NAME	BIRTHDATE	AGE

ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY #	HOME PHONE #	CELL PHONE #	WORK #	MARITAL STATUS	SEX

PATIENT'S EMPLOYER'S NAME	EMPLOYER'S ADDRESS
PERSON RESPONSIBLE FOR BILL (IF DIFFERENT FROM PATIENT)	PHONE #:

PHARMACY

PHARMACY OF CHOICE	PHARMACY PHONE #

PHARMACY ADDRESS	CITY	STATE	ZIP

HAVE YOU BEEN TREATED BY PULMONARY & SLEEP CONSULTANTS , LLC OR SERENITY SLEEP INSTITUTE PREVIOULSY? [ ] YES [ ] NO	DO YOU HAVE A HEALTHCARE DURABLE POWER OF ATTORNEY [ ] YES [ ] NO DO YOU HAVE A LIVING WILL? [ ] YES [ ] NO **(IF YES, PLEASE PROVIDE A COPY OF THE ABOVE DOCUMENTS)**

PHYSICIANS

REFERRING PHYSICIAN NAME (FIRST & LAST)		PRIMARY CARE PHYSICIAN NAME (FIRST & LAST)	
ADDRESS	PHONE #	ADDRESS	PHONE #

OTHER PHYSICIANS CURRENTLY TREATING YOU: (FIRST AND LAST NAME, PHONE, ADDRESS)

EMERGENCY CONTACT (NOT WITHIN THE SAME HOUSEHOLD)

NAME	HOME PHONE #	CELL PHONE #	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

[ ] NO INSURANCE [ ] SELF PAY

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME	EFFECTIVE DATE	INSURANCE NAME	EFFECTIVE DATE
CLAIMS ADDRESS		CLAIMS ADDRESS	
SUBSCRIBER ID NUMBER	GROUP NUMBER	SUBSCRIBER ID NUMBER	GROUP NUMBER
SUBSCRIBER NAME AND ADDRESS		SUBSCRIBER NAME AND ADDRESS	
SUBSCRIBER BIRTHDATE		SUBSCRIBER BIRTHDATE	
SUBSCRIBER SS#	RELATIONSHIP TO PATIENT	SUBSCRIBER SS#	RELATIONSHIP TO PATIENT
EMPLOYER NAME, ADDRESS AND PHONE NUMBER		EMPLOYER NAME , ADDRESS AND PHONE NUMBER	

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Pulmonary & Sleep Consultants, LLC and its divisions to release to the above insurance companies any medical or other information needed for claims reimbursement**. I acknowledge and accept responsibility for payment in full of services rendered to me by Pulmonary & Sleep Consultants, LLC. I understand that payment is expected at the time of service unless arrangements are made in advance.** I permit a copy of this authorization to be used in place of the original HCFA form and request payment of medical insurance benefits to either myself or the party who accepts assignment. (Regulations pertaining to Medicare assignment of benefits apply.) Our office will prepare and file your insurance claim forms for you based on the information you provide to us. To process your claim, it is essential that you provide us with accurate and complete insurance information. It is for this reason that our offices will frequently request updated copies of your insurance card(s) and ask that you complete a new patient registration form.

Patient Signature _____ Date _____