Pulmonary&Sleep Specialists, PC

Patient Registration Form

Date	Social Security Number	Email

Last Name	First Name	MI	Date of Birth

Street Address REQUIRED	Apartment number

City	State	ZIP Code

Mailing address if not same as street address

Primary Phone ◯home ◯cell ◯work	Alt Phone ◯cell ◯home ◯work	Preferred Method of contact: ☐primary phone ☐alternate phone ☐email

Race	Marital Status ☐Single ☐Married ☐Significant Other ☐Divorced ☐Separated ☐Widow(er)

Ethnicity (optional) check one: ☐Hispanic ☐Non-hispanic	Primary Language

Employment ☐Retired ☐Student ☐Full ☐Part ☐Disabled ☐None	Occupation	Employer

PRIMARY EMERGENCY CONTACT INFORMATION

Last Name	First Name	MI	Relationship to patient

Primary Phone	Alternate Phone	Work Phone	Email

PRIVACY INFORMATION

Other than yourself , who do you authorize to receive info?	Relationship to patient	Use as alternate emergency contact? ◯Yes ◯No

Address	Phone number	Email

Other than yourself , who do you authorize to receive info?	Relationship to patient	Use as alternate emergency contact? ◯Yes ◯No

Address	Phone number	Email

PHYSICIAN INFORMATION

Primary Care Physician (PCP)	Address	Phone number

Referring Physician (if not PCP)	Address	Phone number

POLICIES TO BE AWARE OF

Cancellation Policy: 48 hour notice is required to cancel an appointment. Less than 48 hour notice will require a $50 deposit in order to reschedule the appointment; $150 deposit to reschedule a sleep study.
Changes: It is your responsibility to notify us of any changes in your contact information, insurance, or other pertinent data.
Referrals: It is your responsibility to insure referrals from Primary Care Providers have been issued and received. Lack of required referrals will require your appointment to be rescheduled.
Mid-level providers: We utilize a nurse practitioner
Office Hours: 8:30am – 5:00pm Monday – Friday
Medications: All current original medication containers or a current complete list of medications should be brought to all appointments.
Equipment: CPAP or BiPAP machines should be brought to all appointments
Financial Agreement: Payment of co-pays must be made at time of visit.
Privacy Practices: A copy of Pulmonary & Sleep Specialists, PC "Notice of Privacy Practices" may be found on our website: www.pssatl.com or a printed copy will be provided upon request. Our office is HIPAA compliant.

Signature of patient or authorized agent:_____

Relationship to patient if other than patient:_____