

VIJAY PETHKAR, M.D., FCCP
COMPREHENSIVE SLEEP & PULMONARY PRACTICE

PATIENT INFORMATION

Today's Date: _____

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: _____ Social security last 4: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: () _____ Work Telephone: () _____ Cell Phone: () _____

Can we leave or text your health related info to your Cell-phone: Yes / No Home Phone: Yes / No

Emergency Notification: Name: _____ Phone #: _____

Email address: _____ **How were you referred to our office ?** _____

RESPONSIBLE PARTY (If other than patient)

Name: _____ Relationship to patient: _____

Address: _____ Telephone: _____

Employer Name/Address: _____ Telephone: _____

PRIMARY INSURANCE POLICY INFORMATION:

Insurance Co. Name: _____ Subscriber Name: _____

Relationship to you: _____ Date of Birth: _____ Social Security last 4 _____

ID No: _____ Group No: _____

If insurance through an employer, we must have the name and address of the employer:

Name of employer: _____ Street Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE POLICY INFORMATION:

Insurance Co. Name: _____ Subscriber Name: _____

Relationship to you: _____ Date of Birth: _____ Social Security last 4 _____

ID No: _____ Group No: _____

If insurance through an employer, we must have the name and address of the employer:

Name of employer: _____ Street Address: _____

City: _____ State: _____ Zip: _____

PLEASE BRING THE INSURANCE CARDS AND DRIVER'S LICENSE WITH YOU.