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.