Pulmonary and Sleep Associates of Marin

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Novato, CA 94945

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MarinPulmonarySleep.com

PATIENT REGISTRATION AND AUTHORIZATION FORM

*Patient Name:*_____ *DOB:*_____ *Date:*_____

Sex: M ____ *F*____ *SS#:*_____ *email:* _____

Marital Status: Single/Married/Divorced/Widowed _____

Address: _____ *City:* _____ *State:* _____ *Zip:*_____

Phone: home: _____ *cell:*_____ *work:* _____

Are you a student? _____ *Self Employed?* _____

Employer: _____

Address: _____ *City:* _____ *State:* _____ *Zip:*_____

Person financially responsible if other than patient:

Name: _____ *Relation:* _____

*DOB:*_____ *SS#:*_____

Address: _____ *City:* _____ *State:* _____ *Zip:*_____

*Phone: home:*_____ *cell:*_____ *work:* _____

Emergency Contact:

Name: _____ *Relation:* _____

Address: _____ *City:* _____ *State:* _____ *Zip:*_____

*Phone: home:*_____ *cell:*_____ *work:* _____

Primary Insurance: _____

Secondary Insurance: _____

I AUTHORIZE THE FOLLOWING:

____ *I authorize insurance payments to be made directly to*

Pulmonary and Sleep Associates of Marin

____ *I authorize my photograph for the purposes of identification in my medical record*

_____
Print Patient Name

_____ _____
Signature *Date*

If you are signing as a representative of the patient, please provide your name and your relationship to the patient:

_____ _____
Print Name *Relationship*