Pulmonary and Sleep Associates of Marin

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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:* _____

*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*

☐ *I authorize the physicians and other health care providers at Pulmonary and Sleep Associates of Marin to furnish medical diagnosis and treatment to me to care for my medical conditions. I understand there are risks associated with treatment, positive results are not guaranteed, and that I may pursue alternatives to treatment at any time.*

☐ *I consent to treatment by telehealth when appropriate.*

☐ *I authorize Pulmonary and Sleep Associates of Marin to gather data about me from prescribed sleep apnea devices and other wearables when appropriate and to use the data to enhance my treatment.*

☐ *By providing my cell phone number, I consent to receiving text messages, including those that are autodialed, from Pulmonary and Sleep Associates of Marin regarding my care. I understand that my consent is optional and, if given, may be revoked at any time with no effect on my care.*

Cell phone number: _____

☐ *By providing my email address, I consent to receiving emails from Pulmonary and Sleep Associates of Marin regarding my care. I understand that there may be some level of risk that sensitive information about me sent by email could be read by a third party. I understand that my consent is optional and, if given, may be revoked at any time with no effect on my care.*

Email address: _____

_____

Print Patient Name (or representative)

_____ _____

Signature *Date*