

*Pulmonary and Sleep  
Associates of Marin*



100 Rowland Way, Suite 300  
Novato, CA 94945

Phone: 415-878-0225  
Fax: 415-878-0215

[MarinPulmonarySleep.com](http://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: \_\_\_\_\_

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*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

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

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Relationship*