PATIENT INFORMATION

FOR OFFICE USE ONLY

ACCOUNT NUMBER	TYPE OF ACCOUNT	MEDICAL CHART NUMBER	
PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	REFERRING PHYSICIAN	APPOINTMENT WITH DOCTOR

PATIENT INFORMATION

NAME LAST	FIRST	MIDDLE INITIAL	MARITAL STATUS
STREET ADDRESS-INCLUDE APT #	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER — —	OCCUPATION		
NAME OF EMPLOYER/SCHOOL			
STREET ADDRESS	CITY	STATE	ZIP CODE
IN CASE OF EMERGENCY, CONTACT:	NAME	PHONE	
STREET ADDRESS	CITY	STATE	ZIP CODE

BILLING INFORMATION

You should only complete this section if your bills are sent to someone other than the person described above.

NAME OF PERSON TO BILL			HOME PHONE
STREET ADDRESS	CITY	STATE	ZIP CODE
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
NAME OF THEIR EMPLOYER			
STREET ADDRESS OF EMPLOYER	CITY	STATE ZIP CODE	BUSINESS PHONE

INSURANCE INFORMATION:

Get this information from your insurance ID card or form.

NAME OF FIRST COMPANY TO BILL			
STREET ADDRESS	CITY	STATE	ZIP CODE
INSURANCE ID NUMBER	WHOSE POLICY IS IT?	POLICY HOLDER DOB	POLICY HOLDER SS#
NAME OF SECOND COMPANY TO BILL			
STREET ADDRESS	CITY	STATE	ZIP CODE
INSURANCE ID NUMBER	WHOSE POLICY IS IT?	POLICY HOLDER DOB	POLICY HOLDER SS#
NAME OF THIRD COMPANY TO BILL			
STREET ADDRESS	CITY	STATE	ZIP CODE
INSURANCE ID NUMBER	WHOSE POLICY IS IT?	TYPE OF COVERAGE	LOCAL/GROUP NUMBER

"i verify the accuracy of the above information and I authorize the release of information as provided on the reverse of this form."	PATIENT (OR AUTHORIZED) SIGNATURE X	DATE SIGNED
"I am in agreement with the authorization to pay statement on the reverse side of this form."	INSURED'S SIGNATURE X	DATE SIGNED

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STATEMENT OF FINANCIAL RESPONSIBILITY

All professional services rendered by Drs. Bacchetta, Ginsburg, Gorenstein, Sonett, and D'ovidio are the responsibility of the patient, spouse and parent of minor. As a courtesy this office will complete a superbill for you to submit to your insurance carrier, for your reimbursement. The patient, spouse, and parent of minor are responsible for all fees regardless of insurance coverage.

I agree to pay Drs. Bacchetta, Ginsburg, Gorenstein, Sonett, and D'ovidio at the time the services are rendered unless other arrangements have been made with the doctor.

SIGNED ____

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INSURANCE INFORMATION AND ASSIGNMENT

I hereby authorize Drs. Bacchetta, Ginsburg, Gorenstein, Sonett, and D'ovidio to furnish information to insurance carriers, including the Health Care Financing Administration and its agents, needed to determine benefits of the benefits payable for related services.

I request that payment of authorized benefits be made either to me, or on my behalf, to Drs. Bacchetta, Ginsburg, Gorenstein, Sonett, and D'ovidio for any services rendered to me.

I understand that I am responsible for any amount not covered by insurance.

SIGNED ____ DATE: ____________________________

********THIS SIGNATURE REPRESENTS SIGNATURE ON FILE********

NAME: ______________________________

DATE: ______________________________

COLUMBIA THORACIC ASSOCIATES
PATIENT ENCOUNTER FORM -1

Please list all the medications that you are presently taking:

MEDICATION	**DOSE**	**FREQUENCY**

Are you allergic to any medications? Yes No

If yes, please list: ______________________________

____

Do you currently smoke? Yes No

If yes how long ____________ how much ____________

Do you drink alcohol? Yes No Socially

If yes how often ____________ how much ____________

NAME: ______________________________

DATE: ______________________________

PATIENT ENCOUNTER FORM – 2

Do you have a history of (Please circle yes or no)

Hypertension	Yes	No
Diabetes	Yes	No
Elevated Cholesterol	Yes	No
Hepatitis	Yes	No
Stroke	Yes	No
Myocardial infarction	Yes	No
Angina	Yes	No
Congestive heart failure	Yes	No
Pneumonia	Yes	No
Shortness of Breath	Yes	No
Peptic ulcer disease	Yes	No
Kidney stones	Yes	No
Kidney failure	Yes	No
Phlebitis	Yes	No
Urinary infection	Yes	No
Rheumatoid arthritis	Yes	No
Lupus	Yes	No
Emphysema	Yes	No
Pancreatitis	Yes	No
Cholecystitis	Yes	No
Colitis	Yes	No
Diverticulitis	Yes	No
Cancer	Yes	No
Seizure	Yes	No
Thyroid Disease	Yes	No
Osteoporosis	Yes	No
Surgery	Yes	No

If yes, please list operations and date of procedures:

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____

____

____

____

COLUMBIA THORACIC ASSOCIATES

DR: ______________________________ **DATE:** ____________________

Please list the name, address, phone and fax numbers of the DOCTORS WHO HAVE TREATED YOU THAT WE WOULD NEED TO KNOW ABOUT. (ie. Pulmonologist, oncologist, radiation oncologist, Internist, cardiologist, gastroenterologist, etc……)

Patient's Name: ____

Doctor's Name: ____

Address: ____

City/State/Zip: ____

Phone #: ____________________ Fax #: ____________________

Speciality: ____

Doctor's Name: ____

Address: ____

City/State/Zip: ____

Phone #: ____________________ Fax #: ____________________

Speciality: ____

Doctor's Name: ____

Address: ____

City/State/Zip: ____

Phone #: ____________________ Fax #: ____________________

Speciality: ____

Doctor's Name: ____

Address: ____

City/State/Zip: ____

Phone #: ____________________ Fax #: ____________________

Speciality: ____