PULMONARY & SLEEP
OF TAMPA BAY
TAMPA • WESLEY CHAPEL • BRANDON

Phone: 813-490-9495 or 813-654-8100
Fax: 813-654-6555
www.pulmonaryandsleephealth.com
4308 N. Habana Ave. Tampa, FL 33607

Welcome to Pulmonary & Sleep of Tampa Bay. Please fill out this entire form and attach your driver's license and insurance cards so that the front desk person may copy them. PLEASE PRINT.

PATIENT INFORMATION

Name:____

Address: ____

Physical Address: ____

(Needed if you need any medical equipment, i.e. Oxygen)

Home Phone: ________________________ Work: ___________________ Cell:_____________________

Primary Care Physician: __________________________________ Ph:____________________________

D.O.B. __________________ Sex: M F Marital Satus: M S D SSN: ________________________

Emergency Contact: __________________________________ Ph: _______________________________

Email Address: _____________________________________ Pharmacy/ Phone: _____________________

Race:____________________ Ethnicity:__________________________ Language: ___________________

Preferred method of contact: ☐ EMAIL ☐ TEXT MESSAGE ☐ PHONE CALL

INSURANCE INFORMATION

Primary Insurance:________________________ Policy:_____________________ Group:___________

Insurance Address:____

Policy Holder:______________________________________ Date of Birth:________________________

Social Security: ____________________________

Secondary Insurance:______________________ Policy:_____________________ Group: ____________

Insurance Address: ____

Policy Holder:_______________________________________ Date of Birth:_______________________

Social Security: _____________________________

I concent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I acknowledge full financial responsibility for services rendered by Pulmonary and Sleep of Tampa Bay I understand that payment of charges incurred is due at time of service unless other definite financial arrangements have been madeprior to treatment. I agree top ay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I furtherauthorize and request that insurance made directly to Pulmonary and Sleep of Tampa Bay should they elect to receive such payment. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

__________________________ __________________________ ____________________

SIGNATURE WITNESS DATE

If you send this form electronically, please send through our Patient Portal or to this secure email: secure@pasotb.com