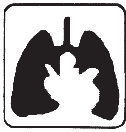


Georgia Pulmonary Group
Georgia Sleep Specialists
Pulmonary Disease, Sleep Disorders & Critical Care Medicine
1800 Tree Lane, Suite 200, Snellville, GA 30078 • 770-979-0367
500 Medical Center Blvd., Suite 160, Lawrenceville, GA 30045 • 770-237-2480

Patient Demographic Information

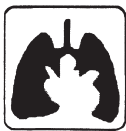
Patient's Name:			Date:
SS#:	DOB:	Age:	Sex: F M
Home Address:	Marital Status: ☐ Widow	☐ Single ☐ Divorced	☐ Married ☐ Separated
City:	State:	Zip:	
Home Phone:	Work Phone:	Cell Phone:	
Email Address:			
Emergency Contact:	Phone #:	Relationship:	
Current Local Pharmacy Name:	Local Pharmacy Phone and/or Address:		
Mail-order Pharmacy:	Mail-order Phone and/or Address:		
Employer Name:	Position:		
Primary Language:	Ethnicity: ☐ Hispanic or Latino Origin ☐ Non-Hispanic		
Race:	☐ American Indian or Alaska Native ☐ Black or African American ☐ White	☐ Asian ☐ Native Hawaiian or Pacific Islander	

REFERRING PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name:	Phone #:
Referring Physician	Phone #:

INSURANCE INFORMATION

Primary Insurance Co. Name:		Subscriber's Name:	Relationship to Patient:
Claim Address:		Subscriber's SS#:	Subscriber's DOB:
Policy #:	Group #:	Employer's Name:	Employer's Phone #:
Secondary Insurance Co. Name:		Subscriber's Name:	Relationship to Patient:
Claim Address:		Subscriber's SS#:	Subscriber's DOB:
Policy #:	Group #:	Employer's Name:	Employer's Phone #:



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GUARANTOR INFORMATION			
Guarantor Name:		Relationship to Patient:	
Guarantor Address:		Guarantor Phone:	
ACCIDENT INFORMATION (If Applicable)			
Automobile Accident		**Work Related Accident**	
Auto Accident: Yes ___ No ___	Date of Accident: ___/___/___	Worker's Comp Accident Yes ___ No ___	Date of Accident: ___/___/___
Auto Insurance Company Name:		Worker's Compensation Insurance Company:	
Claim Adjuster's Name and Phone #:		Claim Adjuster's Name and Phone #:	
Policy Holder's Name & Relationship to Patient:		Employer's Name at the Time of Accident:	
Policy #:	Claim #:	Claim #:	
Accident Information			
Where did the accident/injury occur:		Type of accident:	
Date:	Insurance Company:		Adjuster Name:
Attorney Information:			
Attorney Name:		Address:	
Phone:			
WHO MAY WE THANK FOR REFERRING YOU TO THE PRACTICE?			
Name and Contact Information:			

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient Name Printed__________________________/Patient Signature:____________________________Date:______________

For completion when other than the patient signing or when a minor,

I____am the parent, legal guardian, custodian or have Power of Attorney for this patient, for purpose of treatment, payment or health care operations.

Signature of Parent/Legal Guardian/Custodian/Individual with Power of Attorney:_____________________________________

Printed Name of Signer:____

Relationship to Patient:____

Date:____