

# Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680

Phone (770) 586-0300, Fax (770) 586-0311

## Registration Form

### Patient Information

Name \_\_\_\_\_ Gender  Male  Female

Date of Birth Last \_\_\_\_ / First \_\_\_\_ / Middle \_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Marital Status:  Married  Single  Widow  Divorced  Other \_\_\_\_\_

Employment  Full Time  Part Time  Student  Retired  Other \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Pharmacy Information

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Primary Insurance Information

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

### Secondary Insurance Information

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### Responsible Party: If other than Patient, Please Complete

Person to bill \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell Phone \_\_\_\_\_