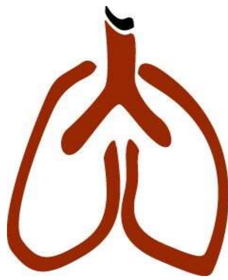

3121 CITRUS TOWER BLVD.
CLERMONT, FL 34711
352-404-5968

2762 DORA AVENUE
TAVARES, FL 32778
352-508-1727

PATIENT DEMOGRAPHICS SHEET

NAME: ________________________ **DOB**: ___________ **MARITAL STATUS**: _________ M ___ F ___

PRIMARY ADDRESS: ____
(Street) (City) (State) (Zip Code)

SECONDARY ADDRESS: ____
(mailing address) P.O. Box

PHONE NUMBER: __________________________ **CELL NUMBER**: ________________________

PATIENT'S EMPLOYER: __________________________________ **WORK PHONE**: _________________

SPOUSE'S NAME: _______________________ PHONE NUMBER: ________________________
PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE): __________________ PH NUMBER: ________________

ADDRESS: ____
(Street) (City) (State) (Zip Code)

NEAREST RELATIVE: ______________________________ **PHONE NUMBER**: ___________________

Were you referred by another physician? If so whom? ___________________________

Who is your Primary Care Physician? ________________________ Phone number: __________________

REASON FOR VISIT TODAY:
____
____

PRIMARY INSURANCE COMPANY: ____

SECONDARY INSURANCE COMPANY: ____

SELF PAY: ___________________

Authorization to Release Information and to Pay Benefits:
I hereby authorize any physician who has treated or attended me or my dependent to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to Pulmonary Critical Care & Sleep Specialist of Lake County, who has treated me or my dependent, any benefits of my insurance that I may have. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient's Social Security Number: ____________________ Email: _____________________________________
Signature: __________________________________ Date: ________________________________