LOIS CARANI, MD, FCCP
PULMONARY MEDICINE

Patient Registration Form

Last Name _____First Name _____ Middle Initial _____

Preferred Name (if different) _____ Former Name (if any) _____

Address _____City_____ State_____ Zip_____

Date of Birth _____ Age _____ Social Security# _____ Gender _____

Home Phone # _____ Work Phone # _____ Mobile Phone # _____

Email _____

Please indicate your preferred / allowed contact method for notifying you of upcoming appointments, test results, pharmacy , medication information, and other *items that may contain protected health information*: Home Ph , Work Ph , Mobile Ph, Email, Patient Portal or NONE . As always, we encourage the use of the secure Patient Portal for all patient communications.

_____Sign Here_____

Marital Status _____Language _____ Ethnicity _____ Race _____

Employer _____ Employer's Address _____

Emergency Contact: Please indicate the person that we may contact /share health info with in the event of an emergency:

Last Name _____ First Name _____ Relationship _____

Home Phone # _____ Mobile Phone# _____

Primary Insurance Co: _____ Policy # _____ Gr # _____

Primary Insurance Address: _____ INS Phone # _____

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Patient Registration Form (cont.)

Primary Insurance Policyholder (IF NOT THE PATIENT).

Is the Policyholder the Financially Responsible Party? _____

Policyholder Last Name _____ First Name _____ DOB _____

Policyholder Address _____City _____ State _____ Zip _____

Secondary Insurance Co: _____ Policy # _____ Gr # _____

Policyholder Last Name : _____ First Name _____ DOB _____

Pharmacy Name _____ Pharmacy Ph # _____ Pharmacy Fax # _____

Pharmacy Address _____

Referring Doctor / PCP: _____ Phone# _____