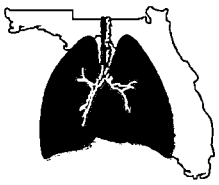

Coastal Pulmonary and Critical Care, P.L.C.

Patient Registration and Information

Date of Birth _____

Name_____ Email: _____

Home Address_____

City_____ State_____ Zip _____

Local Address (If applicable)_____

City_____ State_____ Zip _____

Home Phone ( )_____ Cell ( )_____ Work ( )_____

Social Security Number_____ Sex: Male Female

Marital Status: circle, Married Single Divorced Widowed Partner Other

Active Military Duty: Yes No **Ethnicity:** circle, Hispanic Non-hispanic

Race: circle, White African American or Black Hispanic Asian American Indian Other

Language: circle, English Spanish Indian (includes Hindi and Tamil) Russian Other

Employment: circle, Retired Employed: full time part time Not employed Student

Employer name and address_____

Emergency contact(s)_____ Phone_____Relationship _____

Insurance_____ Policy Holder _____

Policy Holder's Date of Birth_____ Social Security Number_____

Relationship to Patient_____

Referred by _____

Primary Care Physician_____

Pharmacy_____ Phone and/or location_____

Signature_____ Date_____

Do you have advanced directives, living will, or a Power of Attorney? Please Provide Copies.

2639 Dr. ML King Jr. St. N. • St. Petersburg, FL 33704 • Telephone: (727) 822-6661