MARK J. PAMER, DO, LLC
Pulmonary Diseases, Critical Care,
and Internal Medicine

Today's Date _____

PATIENT INFORMATION

Last Name_____ First Name _____ Middle Name_____

Street Address_____

City _____State _____ZIP _____Marital Status_____

Social Security Number _____ Sex _____ Date of Birth _____

Home Phone _____ Cell Phone _____Work Phone _____

Email address:_____

Race: Caucasian, Black, Hispanic, Asian, American Indian/Alaskan National, Refused to Report
Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Refused to Report

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If you are using **home oxygen**, which company do you currently use?_____

If you are using a **home health agency**, which company do you use?_____

Which **pharmacy** do you use? Please include pharmacy name, street name (or cross streets) and/ or phone number_____

_____

Emergency Contact _____Relationship_____Phone Number _____

Insured/ Responsible Party Information

If the insured person is your spouse:

Spouse's Name_____ Date of birth _____ SSN_____

If the insured person is a dependent:

Guardian/ Other Name_____ Date of birth _____ SSN_____

Relationship to patient_____

Please provide photo identification and your insurance cards to the front desk upon check-in. At that time, we will take your photo and attach it to your medical record. **Your co-pay is due at the time of service. We collect it during our check-in process. If you are not able to pay your co-pay, please notify the front desk upon arrival.**

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) signature_____Date_____