

Please Print Clearly	Patient # _		Da	ate:			
Patient Information	า						
Patient Name: (Last)		(First):			M	liddle Initial:	
🛛 Male 🛛 Female DOB:	·	Address: _			Pho	ne:	Alt Phone:
City St	ate 2	Zip:		County:		_ Ref. Doctor:	
SSN:	Marit	tal Status:					
Employment 🗆 Full Time	e 🛛 Part Tim	e 🛛 Self En	nploye	d 🛛 Not Em	ployed 🛛	Retired/ Retire	Date:
RESPONSIBLE PARTY: (IF	OTHER THAN PATIEN	NT AND/ OR IF PAT	FIENT IS A N	11NOR, HE/ SHE WII	LL BE RESPONS	IBLE FOR BILL If address	is the same as patient, write SAME)
Name: (Last) (First)			∕II)	DOB:		Phone:	
Address:							
City:	State	2:		·	Zip:		
Relationship to Patien	t:						
PRIMARY INSURANCE:							
Carrier Name:			١D٠			Group #	
Subscriber Name: (Last						0100p ///	
□ Male □ Female DOB:		SSN:			Relations	ship to Patient	
Employer:						-	
Employer Address:				-	-		
City: State: Zip:							
SECONDARY INSURANCE:							
Carrier Name:				⊃:		Grou	o #:
Subscriber Name: (Las	st) (First) (M	I)					
🛛 Male 🛛 Female DOB	·	SSN:			Relati	ionship to Pat	ient
Employer:				E	mployer	Phone:	
Employer Address:							
City: State: Zip:							

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I assign all insurance payments to OCH Pulmonology & Sleep Center. I understand that any unpaid portion of charges for treatment not paid by my insurance company is my responsibility. I understand that if my balance is not paid in a timely manner and the account is referred for outside collections, I am responsible for any processing fees and/or court costs.

Signature:	Date:			
Name: (Last)	(First)	(DOB)		
EMERGENCY CONTACT: (plea	ase provide a phone	# different from	your own)	
Name: (Last)	(First)	(MI)	DOB:	
Phone: ( )Add	Iress:			_
Address:	_ City,State,Zip:			
Relationship to Patient:	Pref	ferred Pharmacy: _		

NOTE: This is the final page of the OCH Policy/Form. Next page contains revision history only.

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