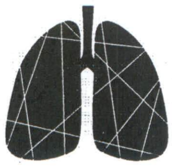

PULMONARY SLEEP & CRITICAL CARE SPECIALISTS

Carlos E. Maas, MD, FACP, FCCP, FAASM
Fabrizio Monge, MD, FCCP, D, ABSM
Lohaliz Bobé, MD, FCCP
Edgardo Soto, MD, FCCP

PATIENT REGISTRATION FORM

Last Name:______________________ First Name:__________________ Middle Initial:______

Address:________________________ City:________________ State:______ ZipCode:________

DOB:______________ Male:____ Female:____ Marital Status: Married Partner Single Widowed Divorced Separated

Social Security Number:______________Home Phone:______________ Cell Phone:______________

Work Phone:______________ Employer: ______________________ May we contact you at work? Y N

Email Address:______________________________ Preferred Method of Contact:______________

Would you like to join our secure web portal to view and/or update all of your personal, health & billing information online? Y N

Spouse:______________ Spouse Phone Number:______________ May we contact your spouse? Y N

May we leave messages related to your medical issues? Y N Would you like to receive Text reminders on your cell phone? Y N

Are you a Seasonal Resident? Y N If yes, please list your Northern Address:______________________

______________________________ Northern Phone Number:______________________

Primary Care Physician:____________________ Referring Physician:______________________

Any other Physicians:____

Emergency Contact: ____________________ Phone Number:______________ Relation:____________

Primary Insurance:______________________ Secondary Insurance:______________________

Responsible Party, if other than patient:____________________ Phone Number:______________

Preferred Local Pharmacy Name:____________________ Phone Number:______________

Address:____

Mail Order Pharmacy Name:______________________ Phone Number:______________

Address:____

Carrier Name:__________________Member ID:________________ Group number:______________

Would you prefer a 90 day supply of your medications? Y N

How did you hear about our practice? Physician Referral________ Friend______ Insurance______ Yellow Pages_______

Internet________ Other (please specify):______________________

Signature of Patient/Responsible Party:______________________________ Date:______________

4235 Kings Highway, Suite 103 . Port Charlotte, FL 33980 . P 941.613.1777 . F 941.613.1779
25086 Olympia Avenue, Suite 300 . Punta Gorda, FL 33950 . P 941.205.5300 . F 941.205.5302