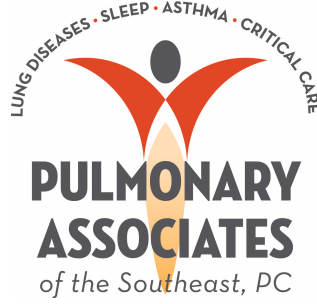


Main Office  
880 Montclair Road, Suite 270  
Birmingham, AL 35213-2437

St. Vincent's Blount  
150 Gilbreath Drive  
Oneonta, AL 35121

Northside Medical Center  
70 Plaza Drive  
Pell City, AL 35125



Gardendale Clinic  
2215 Decatur Highway, Suite 117  
Gardendale, AL 35071

Sylacauga Clinic  
Medical Arts Building, Suite 124  
120 South Anniston Avenue  
Sylacauga, AL 35150

Chelsea Clinic  
16691 Hwy 280  
Chelsea, AL 35043

**Russell G. Beaty, M.D. • Sandra K. Gilley, M.D. • Allan R. Goldstein, M.D. • W. Bishop Kelley, M.D. • Karl T. Schroeder, M.D. • Alan Q. Thomas, M.D.**  
205-802-2000 or 1-866-877-LUNG (5864) Option 1 – Appointments Option 2 – Prescription Refills Option 3 – Doctor's Medical Assistant

### PATIENT INFORMATION

Scheduled Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
DOB \_\_\_\_\_ Sex \_\_\_\_\_ SSN \_\_\_\_\_  
Marital Status \_\_\_\_\_ Driver License # \_\_\_\_\_  
Address \_\_\_\_\_  
ZIP \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Country \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Fax \_\_\_\_\_ Pager \_\_\_\_\_ Email \_\_\_\_\_  
Preferred Communication \_\_\_\_\_

### EMPLOYER

Name \_\_\_\_\_ Status \_\_\_\_\_  
Occupation \_\_\_\_\_ Phone (w/ extension) \_\_\_\_\_

### ASSOCIATED PARTY (POLICY HOLDER)

Name \_\_\_\_\_ Type \_\_\_\_\_  
Relationship \_\_\_\_\_ DOB \_\_\_\_\_

### EMERGENCY CONTACT AND AUTHORIZED CONTACT

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Authorized Contact Name & Number for Personal Health/Billing \_\_\_\_\_  
Authorized 1. \_\_\_\_\_ Authorized 2. \_\_\_\_\_  
Authorized 3. \_\_\_\_\_ Authorized 4. \_\_\_\_\_

### INSURANCE

Do you have insurance coverage?  Yes  No  
 Employer  Exchange  Individual  Worker's Compensation  
Insurance Cards Provided?  Yes  No

**I HAVE READ THE ABOVE AND AGREE THAT THE INFORMATION IS CORRECT.**

**CONSENT FOR TREATMENT** – I consent to necessary treatment, including drugs, medicine, performance of operations and of X-ray, or other studies that may be used by the attending physician, his/her nurse or staff. \_\_\_\_\_

I (aka) authorize Pulmonary Associates of the SE to utilize the medical information obtained during the course of my treatment in medical research and education programs as long as my name & likeness are not revealed and my privacy is completely protected. \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION** – I authorize the release of any and all my treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers. This includes psychological or psychiatric care, attention and treatment. \_\_\_\_\_

**ASSIGNMENT** – I hereby assign Pulmonary Associates of the SE, P.C. all payments for medical and/or surgical services rendered to my dependents due or received from third-party providers. I agree to be responsible for any amount not covered by insurance or other providers. I agree to pay all cost of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection). \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_