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

LUNG DISEASES · SLEEP · ASTHMA · CRITICAL CARE
PULMONARY ASSOCIATES
of the Southeast, PC

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**_____

Print Form Clear Form Save Form