Complete Pulmonary Rehab
190 Aviation Plaza | Hot Springs, AR 71913 | 501.525.2770

General Information

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Is this your legal name? ☐ - Yes | No - ☐

If no, what is your legal name? _____

Date of Birth: _____ Age: _____ Male: ☐ | Female: ☐ Marital Status:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ SSN: _____

Referring Physician: _____

Diagnosis: _____

INSURANCE INFORMATION:

Person Responsible for bill: _____ Date of Birth: _____

☐ Check if address information is same as above.

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Employer Phone: _____

Do you have Medicare? ☐ Yes | No ☐ Policy #: _____

Do you have Medicaid? ☐ Yes | No ☐ Policy #: _____

Are you covered by Insurance? ☐ Yes | No ☐ Name of Insurance: _____

Subscribers Name: _____ SSN: _____ DOB: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____

Subscribers Name: _____ SSN: _____ DOB: _____

Patients Relationship to Subscriber: ☐ - Self ☐ - Spouse ☐ - Child ☐ - Other

IN CASE OF EMERGENCY:

Name of local friend or relative: _____

Relationship to Patient: _____ Phone #: _____ Alternate #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Arkansas Complete Care (dba Complete Pulmonary Rehab). I understand that I am financially responsible for any balance including deductibles, coinsurance, copayment, and/or non covered services. I also authorize Arkansas Complete Care (dba Complete Pulmonary Rehab) or insurance company to release any information required to process my claims.

_____ _____

Patient Signature Date