MLA MASS LUNG & ALLERGY PC

Welcome to Mass Lung & Allergy, P.C.

DEMOGRAPHICS

Last Name: _____ **First Name:** _____

Date of Birth: _ _ - _ _ - _ _ _ _ **Sex:** M☐ F☐ **Email:** _____

Mailing Address: _____

Home Phone: _____ **Cell Phone:** _____ **Preferred Phone:** ☐ Home / ☐ Cell

Can we leave a detailed message? : Y☐ N☐ **Preferred Language:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____

Race: ☐ White / ☐ Black or African American / ☐ American Indian / ☐ Asian / ☐ Pacific Islander / ☐ Other: _____

Primary Care Provider: _____ **Referring Provider:** _____

PHARMACY INFORMATION

Local Pharmacy: _____

Mail Order Pharmacy: _____

Durable Medical Equipment Pharmacy: _____

INSURANCE INFORMATION

** Please present insurance card(s) to office staff **

Insurance Carrier: _____ **ID:** _____

Subscriber: Self / Spouse / Parent **Subscriber Name:** _____ **Subscriber DOB:** _____

INSURANCE AUTHORIZATION & ASSIGNMENT

I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Mass Lung & Allergy, PC for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to Medicare or other insurance carriers any information needed for this or a related Medicare/other insurance company claim.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

I understand it is mandatory to notify Mass Lung & Allergy, PC of any other insurance company who may be responsible for paying for my treatment.

I understand that I will be financially responsible for any and all services not covered by my insurance or rejected/denied by my insurance for any reason (i.e. no referral, incorrect PCP).

SIGNATURE: _____ **DATE:** _____

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Patient Information Release Authorization

Patient Name: _____ DOB: _____

Per privacy laws, no one other than yourself is able to have access to your personal medical information. If you would like another person (e.g. spouse, caregiver, friend, child) to be able to have access to your personal medical information, please share their name and relationship to you on the form below.

If you have any questions regarding this form, please ask one of our staff members. Mass Lung & Allergy, P.C. is not obligated to grant your request.

I authorize the following individuals to have access to information regarding my medical care/treatment.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4	_____	_____
5.	_____	_____

Reminder: If you do not specify anyone on this form, then we cannot release any of your information to anyone other then yourself, your health care provider, and your insurance company.

_____ _____

Signature of Patient/Guardian Date

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Patient Name: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

Contact Phone Number(s): _____

Relationship to Patient: _____

MEDICATION / SUPPLEMENT LIST

Please include all medications and supplements that you are currently taking:

Name	Strength	Frequency / Time of Day

If you prefer, you can bring your prescription vials with you to your appointment. It is very important for your medication list within your medical record to be updated and accurate.

ALLERGIES

Please share any known allergies, including reaction details:

_____

_____

_____

_____

_____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CANCELLATION AND MISSED APPOINTMENT POLICY

I, _____ acknowledge that I have received a copy of the Mass
Patient Name
Lung & Allergy's Notice of Privacy Practices. This notice describes how Mass Lung & Allergy may use and disclose my protected health information, certain restrictions on the use and disclosure of health information and rights I may have regarding my protected health information.

I also acknowledge that I have received a copy of Mass Lung & Allergy's Cancellation and Missed Appointment Policy.

_____ _____

Signature of Patient or Personal Representative Date

_____

Relationship to Patient