LUNG & CHEST
REJMON DEDAJ, MD

Today's Date	

Patient Information

Patient Name: ______________________ Date of Birth: ______________

Phone: Home ______________ Cell ______________ Work ______________

Email: ______________________ Social Security: ______________________

Gender: ☐ Male ☐ Female Language: __________ Race: __________ Ethnicity: __________

Address: ____

City: ______________ State: _____ Zip Code: __________ Marital Status: ☐ S ☐ M ☐ W ☐ D

Occupation: ______________________ Employer: ______________________

Emergency Contact: ______________ Relationship: ____________ Phone: ____________

Emergency Contact: ______________ Relationship: ____________ Phone: ____________

Please check if you would like to receive appointment reminders via email: ☐

Please check if you would like to receive appointment reminders via text message (messaging and data rates may apply): ☐

Please check and explain if you need a translator or special assistance: ☐ ______________________

Preferred Pharmacy Information

Pharmacy Name: ______________________ Phone: ______________

Address: ____

Primary Care and Referring Physician Information

Primary Care Physician: ______________________ Phone: ______________

Address: ____

Referring Physician: ______________________ Phone: ______________

Address: ____

Patient's Name		Patient's DOB	

Responsible Party/Guarantor
☐ Same as patient
Name: ______________________________ Date of Birth: ______________
Address: ____
City: ______________ State: _____ Zip Code: __________ Phone: ______________

Insurance Information
Primary Insurance
Insurance Company Name: ______________________ Phone Number: ______________
Address: ____
Member ID/Policy Number: ____________________ Group Number: ______________
Policy Holder's Name: ______________________ Policy Holder's DOB: ______________
Policy Holder's Social Security: ________________ Relationship to Patient: ____________
Secondary Insurance
Insurance Company Name: ______________________ Phone Number: ______________
Address: ____
Member ID/Policy Number: ____________________ Group Number: ______________
Policy Holder's Name: ______________________ Policy Holder's DOB: ______________
Policy Holder's Social Security: ________________ Relationship to Patient: ____________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Signature of Patient or Guardian: ______________________ **Date:** ______________