

THE CENTER  
FOR LUNG AND  
CHEST SURGERY



102 PARK STREET • GLENS FALLS, NY 12801 • (518) 926-5864 • WWW.GLENSFALLSLUNGANDCHESTSURGERY.COM

**PATIENT INFORMATION**

PATIENT NAME: Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  Single  Married  Other

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Student:  Full Time  Part Time

Patient's Sex:  Male  Female Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Spouse's Sex:  Male  Female Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Ins.: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_ Copay: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

ID#: \_\_\_\_\_ Relation Code: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Ins.: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_ Copay: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

ID#: \_\_\_\_\_ Relation Code: \_\_\_\_\_ Group #: \_\_\_\_\_

**>>> Please notify reception if the office visit is the result of a job injury or an automobile accident.**

I agree to be treated by Glens Falls Hospital staff. I authorize the release of any medical information necessary to process this bill to my insurance company and assign benefits to the Hospital. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_