**Olathe HEALTH**
**Consultants in Pulmonary Medicine**

## PLEASE COMPLETE THE FOLLOWING

Date: _________________ Referred By: ________________________ Family Doctor: ___________________________

Legal Name: ___________________________________________________________________________________
Last Middle First

Address: ___________________________________ City: ___________________ State: ______ Zip Code: __________

Date of Birth: __________________ Marital Status: M S D W Social Security #: ___________________________

Home #: ______________________ Cell #: __________________________ Is it ok to leave a message? Yes No

E-mail: ___________________________________________________________

Employer: ________________________________________ Address: _________________________________________

City: __________________________ State: ____________ Zip Code: ______________ Work #: ___________________

Emergency Contact: ______________________________ Relationship: ___________________

Home #: ______________________ Cell #: __________________________ Work #: __________________________

**Insurance Information:**

Primary Insurance: ______________________________________ Subscriber's Name: ___________________________

Group #: ________________________ Policy #: ________________________________

Subscriber's Date of Birth: ______________

Secondary Insurance: ____________________________________ Subscriber's Name: ___________________________

Group #: ________________________ Policy #: ________________________________

Subscriber's Date of Birth: ______________

**X**_______________________________________________ ___________________
**Signature of Patient/Patient Representative** **Date Signed**