RESPIRATORY CONSULTANTS
OF GEORGIA

Suzette A. Chin, MD FCCP
Timothy Lin, MD FCCP
Melissa Bruce Rhodes, MD FCCP

Registration Form (Please Print)

Account Number ________

First Name: _________________________ MI: ______ Last Name: ___________________________________
Mailing Address: ____
City: _____________________________ State: ___________________ Zip Code: ______________________
Date of Birth: ____/____/_____ Social Security #: ____-____-_____ Gender (circle one): Male or Female

Home Number: (___) ______-__________
___ OK to leave message with detailed information
___ Leave message with call back numbers only
Cell Phone: (___) ______-__________
___ OK to leave message with detailed information
___ Leave message with call back numbers only

Work Number: (___) ______-__________
____OK to leave message with detailed information
____ Leave message with call back numbers only
E-mail: _______________________
____ OK to e-mail health information
____ NOT ok to e-mail health information

Race: ___________________ Ethnicity: ___________________ Preferred 1st Language: ______________
Marital Status (circle one): Single/Married/Widowed Employed (circle one) None/Retired/Full-time/Part-time
Name of Employer: _________________________ City: ___________________________ State: _________
Emergency Contact Name: _____________________ Phone #: _______________Relationship: ___________
Primary Care Physician (first and last name): ___________________________ Phone: __________________
Pharmacy:_________________________ Address:____________________________
Phone #:__________________________ ____________________________

Primary Insurance: __________________
Insured Employer Name: _______________
Insurance Plan Name: _________________
Insurance Plan Name: _________________
ID #: ______________________________
Group #: ___________________________

Secondary Insurance: _________________
Insured Employer Name: ________________
Insurance Plan Name: __________________
Insurance Plan Name: __________________
ID #: ______________________________
Group #: ___________________________

Are you the sponsor of the above insurance? YES / NO
If not, please provide the following:
Spouse/Parent Name: __________________
Date of Birth: ______/_______/_________
Social Security #: _______-_____-_______

Are you the sponsor of the above insurance? YES / NO
If not, please provide the following:
Spouse/Parent Name: ____________________
Date of Birth: ______/_________/________
Social Security #: _______-_______-_________

*Co-pays and balances are due at the time of service. We will bill only two contracted insurance companies, however you

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BREATHINGBETTER.ORG

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are ultimately responsible for all charges whether the insurance company paid for your claim or not. We accept checks, cash, and most credit cards. I hereby authorize Respiratory Consultants of Georgia and staff to disclose my individually identifiable health information to the insurance carrier(s). Respiratory Consultants of Georgia will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

______________________________________ ____________________

Signature of patient or responsible party Date