SLEEP & LUNGS
Naga Chigurupati, MD

2207 Executive Drive, Suite B, Hampton, Va 23666 • Phone 757-224-8919• Fax 757-663-5682

PATIENT INFORMATION:

Referring Physician or PCP _____

Patient's Name _____ Age _____ ☐ Male ☐ Female **SS# _____**

Mailing Address _____ City/State _____Zip _____

Home Phone # _____ Cell phone # _____ Birth date _____

E-mail for Patient Portal Access _____

Marital Status ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

Race _____ Ethnicity _____ Preferred Language _____

Employer_____Occupation_____Work # _____

INSURANCE INFORMATION:

Primary Ins Company _____ ID # _____ Group # _____

Police Holder's Name _____ Employer_____ DOB _____

Primary Ins Company _____ ID # _____ Group # _____

Police Holder's Name _____ Employer_____ DOB _____

EMERGENCY CONTACT

Name _____ Phone # _____ Relationship _____

CONSENT AND AUTHORIZATION:

I hereby give my consent and authorization for Sleep & Lungs to use or disclose my personal health information only if necessary and required for treatment. I understand I have the right to review the provider's privacy notice, to request restrictions and to revoke this consent at any time. This consent and authorization is valid for Sleep & Lungs. I also authorize and request that payment under my insurance programs be made directly to the above provider for any services furnished to me. I understand even though I have insurance, I am responsible for payment.

Signed _____ Date _____