PALOUSE PULMONOLOGY & SLEEP MEDICINE
PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

Vinod Mehta, MD
840 SE Bishop Blvd. Suite 103
Pullman WA 99163-5517

Office (509) 338-6000
Fax (509) 338-6001

PATIENT REGISTRATION

Patient's Legal Name: _____ _____ _____ Last 4 Digits S.S. #:_____
(First) (Middle Initial) (Last)

Preferred Name: _____

Due to updated Federal guidelines, we are required to obtain specific patient information. Please make sure you answer questions 1-6. Thank you.

(1) Patient's Birthdate: _____ **(2) Patient's Age:** _____ **(3) Patient's Gender**: _____

(4) Race (Check One)
□ American Indian/Alaska Native
□ Asian
□ African American
□ White
□ Other Race
□ Declined

(5) Ethnicity (Check One)
□ Not Hispanic or Latino
□ Hispanic or Latino
□ Declined

(6) Primary Language (Please List)
□ _____
□ Declined

Home Address: _____ City: _____ State:_____ Zip Code: _____

Mailing Address: _____ City: _____ State:_____ Zip Code: _____

Home #: _____ Work #: _____ Cell#: _____

Email: _____

Father's Name: _____ DOB:_____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Address: _____ City:_____ State:_____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

Mother's Name: _____ DOB:_____ Last 4 Digits S.S. #:_____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code:_____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address: _____ Occupation: _____

Name of Other: **□ Stepmother □ Stepfather □ Grandparent □ Foster Parent □ Legal Guardian □ Power of Attorney**

Name: _____ Gender:_____ DOB:_____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer Name & Address:_____ Occupation: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone #: _____

Primary Care Physician (If Different): _____ Phone #: _____

Other Provider: _____ Phone#: _____

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EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell #: _____

Name: _____ Relation: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell #: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone #: _____

Preferred Mail Order Pharmacy: _____ Phone #: _____

INSURANCE INFORMATION

Name of Primary Insurance: _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ____

Address: _____ City: _____ State: _____ Zip Code: _____

Customer Service Phone #: _____ Relationship to Patient: _____

Name of Secondary Insurance *(If Applicable)**:*** _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ____

Address: _____ City: _____ State: _____ Zip Code:_____

Customer Service Phone #: _____ Relationship to Patient: _____

Tertiary Insurance *(If Applicable)* **:** _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____
(First) (Middle Initial) (Last)

Policy / Identification # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ____

Address: _____ City: _____ State: _____ Zip Code: _____

Customer Service Phone #: _____ Relationship to Patient: _____