

Patient Introduction Sheet

Augusta Lung Associates, LLP

818 St. Sebastian Way st. 104

(706) 922 - LUNG

Appointment Date: ____/____/____ Appointment Time: ____:____ AM / PM

Today's Date: ____/____/____ Account Number: _____

Physician: _____

.....

Name: _____
Last First Middle

Sex: Male / Female **Date of Birth:** ____/____/____ **Age:** _____

Social Security # : _____

Address: _____

City State Zip Code

Phone: (____) _____ (____) _____ (____) _____
Home Work Mobile

Email Address: _____ @ _____

Employer: _____

Spouse: _____ / ____ / ____
Name Birthdate Spouse's SS#

Emergency Contact : _____
(other than spouse)

Address Phone

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Referring Physician: _____

Primary Physician: _____

Other Physician: _____

If you have had any recent chest x-rays, spiograms, pulmonary function tests or other diagnostic studies please list them below.

| Date | Place | Type of Test / Study |
|------|-------|----------------------|
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