

Pulmonary & Sleep Associates  
515 SW Horne, Suite 200  
Topeka, KS 66606  
785-234-5480

PATIENT DATA SHEET

Today's Date \_\_\_\_\_ Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Male Female  
Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Marital Status M S D W  
Social Security Number \_\_\_\_\_ Student Status Part Time Full Time NA  
Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_  
Referral Physician \_\_\_\_\_ Pharmacy/location \_\_\_\_\_

Emergency Contact Information:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

I hereby authorize Pulmonary & Sleep Associates to release and/or discuss information regarding my medical diagnosis(es) including test results, medications prescribed, treatment plan, hospitalization, billing or other pertinent healthcare information to the person(s) listed below. I recognize that I may limit the scope of this authorization and am doing so here:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
City/State/Zip

Signature \_\_\_\_\_ Relationship \_\_\_\_\_