

## New Patient Information

Name: \_\_\_\_\_, \_\_\_\_\_ Date: \_\_\_\_\_  
(last) (first) (m.i.)  
Date of Birth: \_\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_ Spouse: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about our sleep center? \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other Specialist (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

(If patient is not insured)

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Medical Assistance Number: \_\_\_\_\_

Secondary Insurance Provider (If applicable): \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of birth: \_\_\_\_\_

All Professional Services Rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance.

### **INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize University Services to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to University Services all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

I authorize University Services to release the results of my testing to the physicians listed on this form.

Today's Date: \_\_\_\_\_ Signature: X \_\_\_\_\_

FOR OFFICE USE ONLY:

9/9/2009

ID Verified by \_\_\_\_\_ on \_\_\_\_\_  
name date type of ID

420-00