Dr. Alexander A. Clerk's Office
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Sleep Disorders Clinic

Clinic Confidential Patient Information

Patient Information			
Patient's Name:			
Date of Birth: (MM/DD/YYYY): / /	Social Security #: - -	Sex: ☐ Male | ☐ Female	
Home Address:			
Home #: ( ) -	Work#: ( ) -	Cell # ( ) -	
Email:	Pharmacy Name:	Contact # ( ) -	
EMERGENCY CONTACT:	Relationship:	Contact # ( ) -	
☐Retired | ☐Self Employed | ☐Employed	Employer Name:		
Work Address:			
Education:	☐ Grade School | ☐ High School | ☐ College | ☐ Postgrad | ☐ Graduate School		
Marital Status:	☐ Minor | ☐ Single | ☐ Married | ☐ Widowed | ☐ Separated | ☐ Divorced | ☐ Cohabitating		
Ethnicity/Race	☐ Decline | ☐ Caucasian | ☐ African American | ☐ Asian American | ☐ Native American | ☐ Hispanic ☐ Other Hispanic		
Do you smoke cigarettes?	☐ No | ☐ Yes	If Yes, how many packs a day?	
Current Medications List: ☐ N/A Please list all medications with dosage amount.			

Insurance Information			
Primary Insurance:	☐ HMO ☐ PPO ☐ Other	Subscriber ID:	
☐ Same as Above Subscriber Name:	Group #:	Date of Birth: / /	
Claims Address:		Contact # ( ) -	
Secondary Insurance:	☐ HMO ☐ PPO ☐ Other	Subscriber ID:	
☐ Same as Primary Subscriber Name:	Group #:	Date of Birth: / /	
Claims Address:		Contact # ( ) -	

Guarantor/Responsible Party		
☐ Same as Above Guarantor's Name:	Guarantor's Social Security #: - -	
Home Address:	Contact #: ( ) -	

Referring Physician/Primary Care		
Referring Physician:		
Mailing Address:		
Main #: ( ) -	Fax #: ( ) -	May we consult this physician? ☐ Yes | ☐ No