



Clinic Confidential Patient Information (Please fill out both sides of the form)

SMS # (FOR CLINIC USE): Appointment Date: ___/___/___ Time: ___:___ am/pm

Patient Name: _____
Last First M.I. Maiden Name

Patient Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Birth Date: _____ Sex: ___ F ___ M Fax: _____

Social Security #: _____ - _____ - _____

Temporary Address (If from out of state or country):

Street: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Employer : _____

Employer's Address: _____ Patient's Occupation: _____

City: _____ State: ___ ZIP: _____ Phone: _____ Fax: _____

Background Information

Education (Please circle highest level completed):

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 more
(Grade School) (High school) (College) (Post Graduate)

Ethnic Origin: Caucasian Native American African American Puerto Rican

Mexican American Other Hispanic Asian American Other _____

Household Status (circle one): Single Married Widowed Divorced Separated Cohabiting Other

Do you smoke cigarettes? ___ Yes ___ No

If yes how many packs per day? _____

Medications you are now taking (including dosage in mg / day): _____

Deposit/Copayment: \$ _____ (due at time of visit) or \$ _____ if insurance not contracted with Sleep Medicine Services.

Init. _____

Emergency Contact

Name: _____ Relationship to Patient _____

Address: _____

City: _____ State: _____ ZIP _____ Home Phone: _____ Work Phone _____

Guarantor (person responsible for payment/insurance)

Name: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____ / _____ / _____

City: _____ State: _____ ZIP: _____ Social Security #: _____ - _____ - _____

Home Phone: _____ Work Phone: _____ ext. _____

Employer: _____ Address: _____

Insurance Information

Primary Insurance Company:

Name: _____

ID#: _____

Group: _____

Billing Address: _____

Phone #: _____

Effective Date: _____

Secondary Insurance Company:

Name: _____

ID#: _____

Group: _____

Billing Address: _____

Phone #: _____

Effective Date: _____

Worker's Compensation:

Case #: _____ ID#: _____

Billing Address: _____ Phone #: _____ Date of Injury: _____

Referring or Primary Care Physician (PLEASE NOTE— if you do not provide physician information your reports will not be sent out to your physician/s)

Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ May we consult with this physician? _____ Yes _____ No