SLEEP & PULMONARY CARE CENTER
REGISTRATION FORM

(Please Print And Fill-In Spaces Below Shaded Boxes)

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date:	Age:	Sex:	Social Security No.:	Cell Phone no.:
		❑ M ❑ F		( )

Street address:	Home phone no.:
	( )

P.O. box:	City:	State:	ZIP Code:

Patient's Occupation:	Patient's Employer:	Employer phone no.:
		( )

BILLING/GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)

Full Name	
Address	Phone
	( )

OTHER INFORMATION

Emergency Contact Name:	( )
Referring Physician: Dr.	

INSURANCE INFORMATION

(Please give your insurance card and Photo I.D. to the receptionist.)

PRIMARY INSURANCE:				**Subscriber's name:** (If different from above)
Subscriber's S.S. No.:	**Birth Date:**	**Group No.:**	**Policy No.:**	**Co-Pay Amt.:**
Subscriber's Sex:	Subscriber's Employer:			Employer Phone No.:
❑ M ❑ F				( )
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

SECONDARY INSURANCE (IF APPLICABLE)				**Subscriber's name:** (If different from above)
Subscriber's S.S. No.:	**Birth Date:**	**Group No.:**	**Policy No.:**	**Co-Pay Amt. :**
Subscriber's Sex:	Subscribers Employer:			Employer Phone No.:
❑ M ❑ F				( )
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

If covered by a **THIRD INSURANCE**, Please check here_____

WE WILL FILE INSURANCE FOR OUTPATIENT AND INPATIENT SERVICES. I UNDERSTAND I WILL BE RESPONSIBLE FOR NON-ALLOWED SERVICES THAT ARE NOT COVERED UNDER MY INSURANCE POLICY. I ALSO GIVE CONSENT FOR THE RELEASE OF ANY MEDICAL RECORDS TO MY INSURANCE COMPANY. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

Patient/Guardian signature: ***Date:***