PATIENT ACCOUNT NUMBER
OFFICE USE ONLY

Sleep Disorder Center of Fredericksburg

(Please print clearly)

DATE

PATIENT INFORMATION		
NAME (First, Middle, Last)	DATE OF BIRTH / /	SEX MALE ☐ FEMALE ☐
STREET ADDRESS	TELEPHONE – HOME	
CITY STATE ZIP	TELEPHONE – WORK	
SOCIAL SECURITY NUMBER	TELEPHONE-CELL	
PATIENT RELATIONSHIP TO INSURED ☐Self ☐Spouse ☐Dependent ☐Other	EMPLOYER NAME AND PHONE NUMBER	
REFERRING PHYSICIAN NAME		
REFERRING PHYSICIAN ADDRESS & PHONE NUMBER		

RESPONSIBLE PARTY INFORMATION □ Check here and skip this section if patient is also the responsible party		
NAME (First, Middle, Last)	DATE OF BIRTH / /	SEX MALE ☐ FEMALE ☐
STREET ADDRESS	TELEPHONE – HOME	
CITY STATE ZIP	TELEPHONE – WORK	
SOCIAL SECURITY NUMBER	EMPLOYER	

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER □ Check here if none
INSURANCE CARRIER NAME	INSURANCE CARRIER NAME
STREET ADDRESS	STREET ADDRESS
CITY STATE ZIP	CITY STATE ZIP
PHONE	PHONE
POLICY NUMBER GROUP NUMBER	POLICY NUMBER GROUP NUMBER
POLICY HOLDER'S NAME & SOCIAL SECURITY NUMBER	POLICY HOLDER'S NAME & SOCIAL SECURITY NUMBER

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?			
NAME	RELATIONSHIP	DAYTIME TELEPHONE	EVENING TELEPHONE
STREET ADDRESS	CITY	STATE	ZIP

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Sleep Disorder Center of Fredericksburg to provide any information associated with this illness to my referring physician, consulting physician, durable medical equipment company, other allied health professionals or my insurance carrier. I understand that I am financially responsible for charges not covered by my insurance.

Print Name: _____ Patient Signature: _____ Date: _____

Patient's Agent, Representative or Legal Guardian: _____ Relationship to Patient: _____