PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

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

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

PRIMARY INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Insurance Name:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

SECONDARY INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )
Subscriber's name:	Birth Date / /	Insurance Name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

CONSENT FOR TREATMENT: I hereby consent to and authorize the administration of treatments considered and advisable and necessary in the judgment of the physician.
I understand the information is true to the best of my knowledge. I will receive services today with the understanding that in the event my coverage is not effective, I will be billed and held financially responsible for the services rendered. I understand that I am financially responsible for any balance. I also authorize Eastlake Sleep Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature: *Date:*