SLEEP MEDICINE SERVICES-DR. SCHMIDT-NOWARA

REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First:	Middle:

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

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Primary Care Physician::	Address:	Phone no.:
Referring Physician:	Address:	Phone no.:

INSURANCE INFORMATION

Is this patient covered by insurance?

Person responsible for bill:	Birth date:	Address:	Home phone no.:

Please indicate primary insurance:

Subscriber’s name:	Birth Date	Insurance Carrier:	Subscriber ID:	Group no.:

Patient’s relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber’s ID:	Group no.:

Patient’s relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Cell phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sleep Medicine Services-Dr. Schmidt-Nowara or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**