Georgetown Sleep Center

Patient Name:_____ Date of Birth:_____

Race (Please check on):

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Black or African American
- ❑ White
- ❑ Hispanic
- ❑ Other Race
- ❑ Other Pacific Islander
- ❑ Refuse to Report

Ethnicity (Please Check one):

- ❑ Hispanic or Latin
- ❑ Not Hispanic or Latin
- ❑ Refuse to Report

ACTIVE DUTY HISTORY – PLEASE COMPLETE THE FOLLOWING IF APPLICABLE

Name/Rank: _____

Sex:_____ Age _____ Medical Evaluation Board: ❑ Yes ❑ No

DOE into service: _____ ETS or Retirement Date: _____

MOS: _____

Unit: _____

RELEASE OF INFORMATION

I authorize Georgetown Sleep Center to release information which may include diagnosis, records of any treatment, or any examinations rendered to:

Please print name(s)

□ Spouse:_____ □ Parent: _____

□ Other: _____

_____ _____

Patient Signature Date