



# Georgetown Sleep Center

Experienced care to put your sleep problem to rest.

## REGISTRATION FORM

Patient's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

*Last First M*

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_ Marital Status: \_\_\_

Home Address: \_\_\_\_\_

*Street, City, State and Zip*

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION -IF OTHER THAN THE PATIENT:

Guarantor's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

*Street, City, State and Zip*

Primary Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated and assign directly to Georgetown Sleep Center all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X \_\_\_\_\_

PATIENT/GUARDIAN (If patient is a minor) SIGNATURE

RELATIONSHIP

DATE