Even though we will copy your insurance cards, please complete all of the information requested below.

REGISTRATION FORM

HOW DID YOU HEAR ABOUT US: _____

PATIENT INFORMATION

Patient's Name: _____ Social Security #: _____
Last First Middle

Date of Birth (MM/DD/YY): ___/___/___ Age: _____ Sex: _____ Marital Status: _____ Driver's License: _____

Home Address: _____
City State Zip Code

Home Phone: (_____) _____ Work Phone: (_____) _____ Other (Cell/Pager): _____

Employer: _____ Work Address: _____
City State Zip Code

Email: _____ Pharmacy: _____ Phone:_____
Do we have permission to contact you through email? ☐ Yes ☐ No

IN CASE OF EMERGENCY, NOTIFY: _____ Relationship: _____ Phone (s): (____)_____

INSURANCE INFORMATION

Primary Insurance: _____ ☐ HMO ☐ PPO ☐ Other Phone: _____ Group #: _____

Subscriber's Name: _____ ***Subscriber's Date of Birth***: ___/___/___ ID #: _____

Subscriber's Employer: (☐ *Same as above*) _____ Work Phone: _____

Subscriber SSN:_____ Claims Address: _____
City State Zip Code

Secondary Insurance: _____ ☐ HMO ☐ PPO ☐ Other Phone: _____ Group #: _____

Subscriber's Name: _____ ***Subscriber's Date of Birth***: ___/___/___ ID #: _____

Subscriber's Employer: (☐ *Same as above*) _____ Work Phone: _____

Subscriber SSN:_____ Claims Address: _____
City State Zip Code

RESPONSIBLE PARTY INFORMATION (If other than patient)

Guarantor's Name: _____ Guarantor's Social Security #: _____
Last First Middle

Guarantor's Date of Birth (MM/DD/YY): ___/___/___ Sex: _____ Marital Status: _____ Driver's License: _____

Home Address: _____
City State Zip Code

Home Phone: (_____) _____ Work Phone: (_____) _____ Other (Cell/Pager): _____

Employer: _____ Work Address: _____
City State Zip Code

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above 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.

✕ _____ _____ _____
PATIENT/GUARDIAN (If patient is a minor) SIGNATURE **RELATIONSHIP** **DATE**

Please print out and bring to your appointment.