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