Regional Sleep Center Patient Information Form

DATE:____________________

Is this your first visit with us? ☐ yes ☐ no If no, did you have an ☐ Overnight Oximetry ☐ Sleep Study

Name ______________________ ___________________ ______________ _________________ ☐ male ☐ female
Last First Middle Maiden

Date of Birth ________________________ SS# ________________________________ Race ___________________

Mailing Address ____Apt#______________

City______________________________State_______________________Zip_____________ COUNTY_______________

Home Phone (______)________________ Cell Phone (______)________________ Work phone (_____)_____________

Can we leave a message? ☐ yes ☐ no Can we leave a message? ☐ yes ☐ no Can we leave a message? ☐ yes ☐ no

Martial Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced Mother's Name_____________________
(for registration purposes)

Primary Care Physician _______________________Phone#____________________ Last Seen ___________________

Referring Physician __________________________Phone#____________________

Religious Preference: ______________________ Preferred Language:__________________________________

Are you employed? ☐ yes ******Please complete this box* ☐ no ******If not employed, go to next box*

☐ Full Time ☐ Part Time ☐ LOA ☐ Laid Off Your Occupation ________________________________

EmployerName____________________________________Telephone_________________________ext# ________

Employer Address ____

*****If not employed, please check only **one** of the following

Are you disabled? ☐ yes ☐ no Disability Date __________ Are you retired? ☐ yes ☐no Retirement Date __________

Are you a student? ☐ yes ☐ no If yes, name of school _________________ Are you a homemaker? ☐ yes ☐ no

Next of Kin ________________________________ Relationship ____________________ Phone (______)_______________

Address _____________________________________ City _________________ State ___________ Zip ________________

Emergency Contact _________________________ Relationship ____________________ Phone (______)_______________

Address _____________________________________ City _________________ State ___________ Zip ________________

Insurance Company Name ___________________________________ Subscriber Name on Card ____________________________

Insurance ID # ____________________________ Group # ____________________

Subscriber's Employer ___________________________________ Birth date ______________ SS# _______________________

Secondary Insurance _______________________________________ Subscriber Name on Card ____________________________

Insurance ID # ____________________________ Group # ____________________

It is the policy of this office to keep all medical records confidential. There may be occasions when you need this information released to another office/person. Please answer the following questions and authorize us to give your confidential information in these situations:

1. May we leave your medication information, including test results, on an answering machine or give it to another person, such as; a spouse, adult, or caregiver? ☐ yes ☐ no Names of person's to notify or leave messages:____________________________

2. May we leave detailed appointment reminders or messages to call us back on your answering machine at home, work, or cell phone? ☐ yes ☐ no

I, the understand, give my authorization to treat and assign directly to **Vincent A Viscomi, Tareck A. Kadrie, or Anuj Chandra, MD**, all medical benefits, if any otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges other or not paid for by insurance. I hereby authorize the physician to release all information necessary to secure payment of benefits and authorize the use of the signature on all insurance submissions. I authorize release of medical information for treatment.

Signature____ Date:_____________________