#           



                       

**NEW PATIENT REGISTRATION FORM**



**How did you hear about us?** Doctor Patient Internet/Website TV Radio Other

**PATIENT INFORMATION**

Patient’s Name: Last

First

Middle Initial

Social Security #:

Date of Birth:

Age:

Gender:

Marital Status: (S,M,W,D)

Address:

City/State:

Zip:

Home Phone:

Cell Phone:

Work Phone:

Employer:

Email:

Pharmacy Name:

## May we contact you through email? Yes No

Emergency Contact Name:

Relationship:

Phone Number:

**INSURANCE INFORMATION**

Primary Insurance Name: Policy Holder Name:

Policy Holder Date of Birth: Relationship to Patient:

ID #:

Group #:

Secondary Insurance Name: Policy Holder Name:

Policy Holder Date of Birth: Relationship to Patient:

ID #:

Group #:

**RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)**

Guarantor’s Name: Last

First

Middle Initial

Social Security #:

Date of Birth:

Age:

Gender:

Marital Status: (S,M,W,D)

Address:

City/State:

Zip:

Home Phone:

Cell Phone:

Work Phone:

Employer: Email:

I, the undersigned, certify that I or my dependent have insurance coverage as indicated above. I assign directly to Valley 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/Parent or Legal Guardian Signature Relationship Date

Please print and bring to your appointment if you have completed this form from our website.