Sleep Management Institute

PATIENT REGISTRATION

(Please Print)

Patient Name: _____ Birth Date: ____-____-____ Age: _____
(Last) (First) (MI)

SSN: _____-_____-_____ Sex: □Male □Female Marital Status: □S □M □D □W □Sep □DP

Address: _____
(Street) (City) (State) (Zip)

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
(Home) (Mobile) (Work)

Email Address: _____ ☐ Please do not send me email updates

Employer: _____ Address: _____
(Street) (City) (State) (Zip)

Referred By: _____ Phone #: (_____) _____-_____
(Last) (First)

Primary Care MD: _____ Phone #: (_____) _____-_____
(Last) (First)

Primary Insurance: _____ Phone #: (_____) _____-_____

Address: _____

I.D. #: _____ Group #: _____

Insured's Name: _____ DOB: ____-____-____ SSN: _____-___-_____

Relationship to Patient: _____ Insured's Employer: _____

Employer's Address: _____ Phone #: (_____) _____-_____

Secondary Insurance: _____ Phone #: (_____) _____-_____

Address: _____
(Street) (City) (State) (Zip)

I.D. #: _____ Group #: _____

Insured's Name: _____ DOB: ____-____-____ SSN: _____-___-_____

Relationship to Patient: _____ Insured's Employer: _____

Employer's Address: _____ Phone #: (_____) _____-_____

Emergency Contact: Name: _____ Relationship: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone #: (_____) _____-_____ Work #: (_____) _____-_____

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1) I hereby give consent to Sleep Management Institute to:

- Render testing and treatment.
- Use and disclose my Protected Health Information for purposes of treatment, payment and health care operations as outlined in our Notice of Privacy Practices for Protected Health Information.
- Act as my agent in helping obtain payment from my insurance company(s).
- Receive payments directly from my insurance company(s).

2) I authorize Optimum Sleep Associates to act as an agent for Sleep Management Institute to use and disclose my Protected Health Information for the purpose of arranging durable medical equipment or other treatment as necessary.

3) I understand that I am responsible for all charges incurred, even if they are not covered by my insurance plan, and verifying whether or not Sleep Management Institute is a covered facility in my insurance plan.

Patient Signature (or Representative): _____ Date: ____-____-____

Print Representatives Name: _____ Relationship:_____