Please fill out, sign and date, and bring this form with you to your appointment. Please bring your insurance card(s) to your appointment. Thank you.

## SOMNOS SLEEP DISORDERS CENTER

### PATIENT AND INSURANCE REGISTRATION FORM

PATIENT'S NAME:FIRST _____ MI _____ LAST _____ DATE _____

ADDRESS _____ E-MAIL _____

CITY _____ STATE _____ ZIP _____ PHONE _____

DATE OF BIRTH _____ AGE _____ GENDER _____ SS# _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS ☐M ☐S ☐D ☐W SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE _____

REFERRING PHYSICIAN _____

HAVE YOU SEEN/DO YOU SEE A PULMONOLOGIST OR SLEEP SPECIALIST? ☐YES ☐NO

If yes, please list the name of the Physician _____

**INSURANCE INFORMATION OR CHECK BOX IF SELF-PAY/NO INSURANCE:** ☐

| *Name of Insurance Carrier* | *Policy/ID Number* | *Group #* | *Primary or Secondary?* |
|---|---|---|---|
| | | | ☐ / ☐ |
| | | | ☐ / ☐ |
| | | | ☐ / ☐ |

Name of Insured _____ Date of Birth _____ Relationship _____

**INSURANCE AUTHORIZATION**

I authorize any holder of medical or other information about me to release to the insurance companies any information needed to determine these benefits or benefits for related services. I also authorize the payments from these insurance companies to be paid directly to Somnos Laboratories Incorporated for services provided. I realize I will be responsible for any amount the insurance company does not allow for the services. To the best of my knowledge, the facts stated herein are complete and true.

**AUTHORIZE TO OBTAIN OR RELEASE INFORMATION:**

I hereby authorize Somnos Laboratories Incorporated to obtain any medical information or records which will aid in the diagnosis or treatment of my illness. I also authorize Somnos Laboratories Incorporated to release any information acquired in the use of my testing to other physicians or to insurance companies.

**SIGNATURE** _____ **DATE** _____