Ashtabula Sleep Medicine - New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: ______________________ Last Name: ________________________ MI: ___

Home Phone (_____) ____________ Cell Phone (_____) _____________ Work Phone (_____) ____________

The best time to contact me is: ☐ Morning ☐ Mid-Day ☐ Evening on ☐ Home phone ☐ Cell phone ☐ Work phone

Email Address__________________________________ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Address: ____________________________________City:_________________ State: _______ Zip: ___________

Date of Birth (M/D/Y): ____ /____ /_______ Gender: ☐M ☐ F Social Security Number (SSN): _________________

Height: Feet_____ Inches_____ Weight (lbs): ______ Marital Status: ☐ Married ☐ Single ☐ Life Partner ☐ Minor

Spouse or Parent/Guardian (if minor) Name: _____________________________________

Emergency Contact: __________________________ Relationship: ______________ Phone___________________

REFERRED BY: ____

Employer Information

Employer: _____________________________________ Phone: (____) _____________Fax: (____)_____________

Address: _________________________________City_______________________ State: ______Zip: __________

Health Insurance Information

Patient's Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured (First, MI, Last): _________________________________ Insured DOB (M/D/Y): ____ /____ /______

Ins Co.: ____ Ins ID: ___________________________

Group #: _______________________________________ Plan Name: ____________________________________

Business Address__________________________________ City_________________ State: _____ Zip __________

Phone: (______)_______________Fax: (______)_______________ Email: _________________________________

Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? ☐ YES ☐ NO IF **YES**, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured (First, MI, Last): _______________________ Insured DOB___ /___ /_____

Ins Co.: ____ Ins ID: ___________________________

Group #: _______________________________________ Plan Name: ____________________________________

Business Address__________________________________ City_________________ State: _____ Zip __________

Phone :(_____)______________ Fax: (______)_______________ Email: ___________________________________

Please present your secondary insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _________________________________ Phone: ________________________

ENT: ____ Phone: ________________________

SLEEP DOCTOR: ____ Phone: ________________________

DENTIST: ____ Phone: ________________________

OTHER MD: ____ Phone: ________________________

OTHER MD: ____ Phone: ________________________

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _______ Date:______