

ARLINGTON SLEEP MEDICINE, Ltd.
PATIENT INFORMATION SHEET
 PLEASE PRINT CLEARLY

PATIENT ACCOUNT NUMBER
OFFICE USE ONLY

DATE

PATIENT INFORMATION			
NAME (First, Middle, Last)	DATE OF BIRTH / /	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
STREET ADDRESS		TELEPHONE – HOME	
CITY	STATE	ZIP	TELEPHONE – WORK
SOCIAL SECURITY NUMBER		TELEPHONE-CELL	
PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other		EMPLOYER NAME AND PHONE NUMBER	
REFERRING PHYSICIAN NAME			
REFERRING PHYSICIAN ADDRESS & PHONE NUMBER			

RESPONSIBLE PARTY INFORMATION <input type="checkbox"/> Check here and skip this section if patient is also the responsible party			
NAME (First, Middle, Last)	DATE OF BIRTH / /	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
STREET ADDRESS		TELEPHONE – HOME	
CITY	STATE	ZIP	TELEPHONE – WORK
SOCIAL SECURITY NUMBER		EMPLOYER	

PRIMARY INSURANCE CARRIER		SECONDARY INSURANCE CARRIER <input type="checkbox"/> Check here if none	
INSURANCE CARRIER NAME		INSURANCE CARRIER NAME	
STREET ADDRESS		STREET ADDRESS	
CITY	STATE	ZIP	CITY STATE ZIP
PHONE		PHONE	
POLICY NUMBER	GROUP NUMBER	POLICY NUMBER	GROUP NUMBER
POLICY HOLDER'S NAME & SOCIAL SECURITY NUMBER		POLICY HOLDER'S NAME & SOCIAL SECURITY NUMBER	

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?			
NAME	RELATIONSHIP	DAYTIME TELEPHONE	EVENING TELEPHONE
STREET ADDRESS		CITY	STATE ZIP

AUTHORIZATION TO PAY PROVIDER
FOR SERVICES RENDERED, I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO ARLINGTON SLEEP MEDICINE, LTD.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

Print Name: _____ Patient Signature: _____ Date: _____

Patient's Agent, Representative or Legal Guardian: _____ Relationship to Patient: _____