Patient Information Form

Please Review and Update

Patient Name: _____

Patient ID #: _____ DOB: _____

Address: _____ Race: _____ Ethnicity: _____

_____ Age: _____ Sex: _____

SSN: _____ Language: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Emergency Contact: _____ Relationship: _____

_____ Emergency Contact Phone: _____

Guarantor Information

Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Referring Provider Information

Referring Provider: _____

Referring Provider Phone Number: _____

Referring Provider Address: _____

_____

Insurance Information

Primary Insurance: _____

Certificate #: _____ Group#: _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance: _____

Certificate #: _____ Group#: _____

Subscriber Name: _____ Subscriber DOB: _____

Authorization to Pay Benefits to Provider: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Emerald Coast Pediatric Sleep Consultants, LLC when they accept assignment.

Authorization to Release Medical Information: I hereby authorize my Provider, Emerald Coast Pediatric Sleep Consultants, LLC to release any information necessary for my course of treatment.

_____ Date: _____

Signed (Parent or Guardian or Patient if over age 18)