Ohio Sleep Medicine Institute – New Patient Registration Form

Information Form

First Name _____ **Last Name** _____ **M.I.** _____ **Age:**_____ ☐ **Male** ☐ **Female**

Date of Birth _____/ _____/_____ **Marital Status:** ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home phone _____ **Cell. phone** _____ **Work phone** _____

Email _____

Occupation _____ **Employed by** _____ **Social Security #** _____

Race ☐ White ☐ Asian ☐ Black/African Amer. ☐ Amer. Indian/ Alaska Native ☐ Unknown ☐ Declined ☐ Other _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Declined

Preferred Communications to confirm appointments: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text ☐ Email

How did you hear about us? _____**Would you like to receive our monthly e-newsletter?** ☐ Yes ☐ No

Spouse's Name (if applies) or Parent Name (if patient is minor) _____

Spouse/Parent Date of Birth _____/_____/_____ **Social Security #** _____ **Employed by** _____

Home phone _____ **Cellular phone** _____ **Work phone** _____

If applies, name & address of other person to be billed _____

Family Phys. _____ **Address** _____**Tel:** _____

Referring Phys. _____ **Address** _____ **Tel:** _____

Pharmacy _____ **Address** _____ **Tel:** _____

Insurance Information

Primary Insurance Carrier	Subscriber Name	Date of Birth	Certificate #	Group #

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Authorization to Release Insurance Information for Claim Processing & Assignment of Benefits

I authorize Ohio Sleep Medicine to submit a claim to my insurance carrier, its intermediaries or Medicare for all services rendered by Ohio Sleep Medicine Institute and to release any medical information necessary to process that claim. I authorize direct payment of medical benefits to Ohio Sleep Medicine Institute for services rendered.

_____ _____/_____/_____

Patient or Authorized Signature **Date**

Medical Records Release Authorization

I authorize Ohio Sleep Medicine Institute to disclose complete information to

Dr(s). _____

concerning the medical findings and treatment concerning my illness from the period beginning _____/_____/_____

until the conclusion of such treatment.

_____ _____/_____/_____

Patient or Authorized Signature **Date**