Advanced Respiratory & Sleep Medicine

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Pulmonary/Critical Care/Neurocritical Care/Sleep Medicine

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New Patient Facesheet Form

Patient Information:			
Last Name:	First Name:		Date:
Name of Parent/Guardian/Conservator:			
Address:			
City:		State:	Zip:
Tel: H:	W:	C:	email:
May we contact or leave messages on phone?			May we email you?
			Confidential information will not be sent via email.
DOB:	Sex: ☐ Male ☐ Female		Social Security No.:

Employer:	Occupation:
	Contact info (address, telephone)
Referred by:	
Primary Provider:	
Other Physicians:	

Emergency Contact Information:	
Name:	Relation:
Emergency Phone:	

Primary Insurance Health Insurance Information:			
If different than patient, Insured's Name:			Soc. Sec No.:
Insured's Employer:			
Insurance Company:	ID No.:		Group No.:
Insurance Co. Address:			
City:	State:		Zip:
Secondary Insurance:			Insurance Cards Required
If different than patient, Insured's Name:			Soc. Sec No.:
Insured's Employer:			
Insurance Company:	ID No.:		Group No.:
Insurance Co. Address:			
City:	State:		Zip:
All information is confidential			

Authorization and Signature: The provided information is true to the best of my knowledge. I authorize the release of this confidential protected health information for treatment, payment, billing, or health care operations for SKAND corporation, Sleep Well Medical Clinic and associated Health Providers. I understand that I may not receive services if I do not authorize this. The information to be disclosed is protected by law.

Signature:_____