Advanced Respiratory & Sleep Medicine

Sharad Dass, MD, FCCP, FAASM
Pulmonary/Critical Care/Neurocritical Care/Sleep Medicine

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New Patient Facesheet Form

Patient Information:												
Name of Parent/Guardian/Conservator: Address: City:				_	nation:							
Address: City:		First Nar	irst Name:			Date:						
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May we contact or leave messages on phone? May we email you? Confidential information will not be sent via email. DOB: Sex: Maile Female Social Security No.: Employer: Contact info (address, telephone) Referred by: Primary Provider: Other Physicians: Emergency Contact Information: Relation: Emergency Phone: Primary Insurance Health Insured's Name: Soc. Sc No.: Insurance Company: In D No.: Group No.: Insurance Cordadress: City: State: Zip: Soc. Sc No.: Insurance Cards Required if different than patient, Insured's Name: Soc. Sc No.: Insurance Company: Insurance Company: Insurance Company: Group No.: Insurance Company: Insurance Company: Soc. Sc No.:	City:			State	:		Zip:					
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All information is confidential	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.

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Signature:			
SIZHALUI E.			