Snore No More Sumter LLC - New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _________________________ Last Name: ___________________________ MI: ___

Home Phone (_____) _____________ Cell Phone (_____) ______________ Work Phone (_____) _____________

The best time to contact me is: □ Morning □ Mid-Day □ Evening on □ Home phone □ Cell phone □ Work phone

Email Address______________________________________ Would you like to receive our e-newsletter? □ Yes □ No

Address: ____City:___________________ State: _______ Zip: ____________

Date of Birth (M/D/Y): ____ /____ /_______ Gender: □M □ F Social Security Number (SSN): ___________________

Height: Feet_____ Inches_____ Weight (lbs): ______ Marital Status: □ Married □ Single □ Life Partner □ Minor

Spouse or Parent/Guardian (if minor) Name: ____

Emergency Contact: _____________________________ Relationship: _______________ Phone_____________________

REFERRED BY: ____

Employer Information

Employer: ____ Phone: (____) ______________Fax: (____)______________

Address: ______________________________________City__________________________ State: ______Zip: ___________

Health Insurance Information

Patient's Relationship to Primary Insured: □ Self □ Spouse □ Child □ Other

Name of Insured (First, MI, Last): _____________________________________ Insured DOB (M/D/Y): ____ /____ /______

Ins Co.: ____ Ins ID: ______________________________

Group #: ____ Plan Name: ____

Business Address______________________________________ City__________________ State: _____ Zip ___________

Phone: (______)________________Fax: (______)________________ Email: _____________________________________ *Please present your insurance card so we can photocopy it.*

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? □ YES □ NO IF **YES** , PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other

Name of Insured (First, MI, Last): _________________________ Insured DOB___ /___ /_____

Ins Co.: ____ Ins ID: ______________________________

Group #: ____ Plan Name: ____

Business Address______________________________________ City__________________ State: _____ Zip ___________

Phone :(_____)_______________ Fax: (______)________________ Email: ______________________________________ *Please present your secondary insurance card so we can photocopy it.*

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: ____________________________________ Phone: ___________________________

ENT: ____ Phone: ___________________________

SLEEP DOCTOR: ____ Phone: ___________________________

DENTIST: ____ Phone: ___________________________

OTHER MD: ____ Phone: ___________________________

OTHER MD: ____ Phone: ___________________________

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _______ Date:______