NORTH COLLIER SLEEP DIAGNOSTIC CENTER
NEW PATIENT REGISTRATION

Date:_____

Last Name:_____ First Name:_____

Date of Birth:_____ SSN:_____

Height_____ Weight_____

Home Phone(___)_____ Work Phone:(___)_____

Cell Phone:(___)_____

Local Address: _____

Northern Address:_____

Employer:_____

Spouse Name: _____

Spouse Work Phone:(___)_____Cell Phone:(___)_____

Emergency Contact (other than spouse:)_____

Emergency Contact Phone: _____

Relationship to you_____

Primary Care Physician:_____

Physician Phone Number(___)_____

Physician Ordering the Sleep Study_____

Insurance and Billing

Primary Insurance_____

Policy or Member # _____

Group # _____ Phone #_____

Secondary Insurance_____

Policy or Member # _____

Group # _____ Phone #_____

Policy Holder (If different than the patient)_____

Relationship to patient_____

I agree to bring my insurance cards and photo ID to my first visit.

I understand that I am fully responsible for the amounts billed to me for professional services rendered to me that are not covered by Medicare and/or my insurance including the deductible and co-payments. I will be expected to pay my co-payments at each visit.

Patient Signature:_____ Date:_____