UNITED SLEEP DIAGNOSTICS INC.

Everyone deserves a good night's sleep

Date:___/____/____

For internal use only
CRM Patient ID#_____

Patient Registration Form • Please Provide Your Insurance Card To The Technician

Last Name:_____First Name:_____MI:_____Generation_____

Guarantor:_____

Is this guarantor a legal representative? Yes☐ No☐ Referring Physician:_____

Social Security No:_____ Sex: M☐ F☐

Home Address:_____ Rent☐ Own☐ Date of Birth:_____/_____/_____

Address line 2:_____ Marital Status:

City:_____State:_____Zip Code:_____ Single☐ Married☐ Divorced☐ Widowed☐

Employer:_____ Employment Status (check one)

Employer Address:_____ Employed☐ Retired☐

Home Phone:_____Cell:_____ Full Time Student☐ Part Time Student☐

Work Phone:_____Ext:_____E-mail:_____

Primary Insurance

Insurance Company:_____Group Number:_____Co-Payment Amount_____

Policy Number:_____Deductible:_____Effective Dates

Relationship to Insured:_____ From:_____/_____/_____

Policy Holder Information

To :_____/_____/_____

Last Name:_____First Name:_____MI:_____Generation_____

Policy Holder Address:_____

Address line 2:_____ Date of Birth:_____/_____/_____

City:_____State:_____Zip Code:_____ Home Phone:_____

Employer:_____ Work Phone:_____

Employer Address:_____ Employee ID:_____

Secondary Insurance

Insurance Company:_____Group Number:_____Co-Payment Amount_____

Policy Number:_____Deductible:_____Effective Dates

Relationship to Insured:_____ From:_____/_____/_____

Policy Holder Information

To :_____/_____/_____

Last Name:_____First Name:_____MI:_____Generation_____

Policy Holder Address:_____

Address line 2:_____ Date of Birth:_____/_____/_____

City:_____State:_____Zip Code:_____ Home Phone:_____

Employer:_____ Work Phone:_____

Employer Address:_____ Employee ID:_____

Name of Local friend or relative:_____Relationship to patient:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to United Sleep Diagnostics Inc. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ Date:_____/_____/_____