# PACIFIC SLEEP CENTER

EDMONDS 425-670-9097 SEATTLE 206-363-1111

PLEASE FILL IN (PRINT) THE FOLLOWING INFORMATION COMPLETELY

## *PATIENT INFORMATION*

NAME: _____ BIRTH DATE:_____ AGE:_____
FIRST M.I. LAST MM/DD/YYYY

BY WHAT NAME WOULD YOU PREFER TO BE ADDRESSED?_____ GENDER: _____MALE _____FEMALE

ADDRESS:_____ APT #:_____ CITY:_____ STATE:_____ ZIP CODE:_____

P.O. BOX ADDRESS:_____
BOX NUMBER CITY STATE ZIP CODE

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____ E-MAIL ADDRESS: _____

MARITAL STATUS (CIRCLE): SINGLE MARRIED DOMESTIC PARTNER WIDOWED SOCIAL SECURITY NO._____

REFERRED TO OFFICE BY: _____ HOW DID YOU HEAR ABOUT US? _____

## *EMPLOYER INFORMATION*

NAME:_____ WORK PHONE: (_____)_____

ADDRESS:_____
CITY STATE ZIP CODE

## *SPOUSE/PARENT INFORMATION*

SPOUSE OR PARENT NAME:_____ BIRTH DATE:_____ PHONE: (____)_____
(PLEASE CIRCLE ONE) MM/DD/YYYY

ADDRESS:_____
CITY STATE ZIP CODE

SOCIAL SECURITY NO._____

EMPLOYER NAME:_____ WORK PHONE: (_____)_____

ADDRESS:_____
CITY STATE ZIP CODE

## *EMERGENCY CONTACT INFORMATION*

NAME:_____ RELATIONSHIP: _____ PHONE: (_____)_____

ADDRESS:_____
CITY STATE ZIP CODE

## *INSURANCE INFORMATION*

**PRIMARY INSURANCE** NAME:_____ ____HMO ____PPO GROUP NUMBER:_____

NAME OF SUBSCRIBER:_____ SUBSCRIBER ID NUMBER:_____

SUBSCRIBER RELATIONSHIP TO PATIENT: (PLEASE CIRCLE ONE) SELF SPOUSE PARENT OTHER:_____

INSURANCE ADDRESS:_____
CITY STATE ZIP CODE

**SECONDARY INSURANCE** NAME:_____ ____HMO ____PPO GROUP NUMBER:_____

NAME OF SUBSCRIBER:_____ SUBSCRIBER ID NUMBER:_____

SUBSCRIBER RELATIONSHIP TO PATIENT: (PLEASE CIRCLE ONE) SELF SPOUSE PARENT OTHER:_____

INSURANCE ADDRESS:_____
CITY STATE ZIP CODE

PLEASE READ THE FINANCIAL AGREEMENT AT www.pacsleep.com/registration.html BEFORE SIGNING BELOW

A record is kept of the health care services we provide to you. You have the right to see or obtain a copy of the record. You may ask that corrections be made to the record. We will not disclose your record to others unless you direct us to do so or if authorized or compelled to do so by law.

AGREEMENT: I hereby consent to and authorize the administration of all treatments as deemed necessary by the attending physician. I assume all responsibility for payment. I authorize my insurance benefits to be paid directly to the physician. I authorize the physician to release any information required by my insurance company. No other records shall be released without my signed consent. I have read, understand and agree to the terms and policies outlined in the financial agreement.

Signed:_____ Date:_____