

# Advanced Respiratory & Sleep Medicine

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## New Patient Facesheet Form

Patient Information:			
Last Name:	First Name:	Date:	
Name of Parent/Guardian/Conservator:			
Address:			
City:	State:	Zip:	
How long have you lived at this address?			
Tel: H:	W:	C:	email:
May we contact or leave messages on phone?			May we email you?
Confidential information will not be sent via email.			
DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.:	
Ht:	Marital Status:		
Wt:	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	
	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	
	<input type="checkbox"/> Domestic Partner		
Employer:		Occupation:	
Contact info (address, tel)			
Referred by:			
Primary Provider:			
Other Physicians:			

Emergency Contact Information:	
Name:	Relation:
Emergency Phone:	

Health Insurance Information:	
Primary Insurance	
If different than patient, Insured's Name:	Soc. Sec No.:
Insured's Employer:	
Insurance Company:	ID No.: Group No.:
Insurance Co. Address:	
City:	State: Zip:
Secondary Insurance: <span style="float: right;">Insurance Cards Required</span>	
If different than patient, Insured's Name:	Soc. Sec No.:
Insured's Employer:	
Insurance Company:	ID No.: Group No.:
Insurance Co. Address:	
City:	State: Zip:
<i>All information is confidential</i>	

**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.

**Signature:** \_\_\_\_\_