GUAM SLEEP CENTER

PATIENT REGISTRATION

Date Complete:______________________________

PATIENT INFORMATION			
NAME: *Last*	*First*	*Middle*	
Phone: (H) (W) (C)		Email:	
Birthdate: / /	Age:	Sex: ____M ____F	SS#: ___ ___ ___ - ___ ___ -___ ___ ___ ___
Nationality:	Religion:	Veteran: ____ Yes ____ No	
___Single ___ Married ___Widowed ___ Separated ___ Divorced		Maiden Name:	
Residential Address:	City	State	Zip
Billing Address:	City	State	Zip
Occupation:	If Military, Specify Grade:		
Length of Employment:	Employment Status: ___ Full Time ___ Part time ___ Retired ___ Self Employed		
Employer:	Employer Address:		
Spouse:	Work Phone:	Ext:	
Employer:	Employer Address:		
Emergency Contact:			
Relationship:	Phone: (H)	(W)	
Referred By:	Primary Care MD:		

PRIMARY INSURANCE COMPANY		
Insurance Name:	Policy Or ID #:	
Address:	Group #:	
Phone:	Eff Date:	Expiration Date:
Subscriber:	Phone:	SS#:
Relationship to Patient:	Employment Status:	
Employer:	___ Full Time ___ Part time ___ Retired ___ Self Employed	

SECONDARY INSURANCE COMPANY		
Insurance Name:	Policy Or ID #:	
Address:	Group #:	
Phone:	Eff Date:	Expiration Date:
Subscriber:	Phone:	SS#:
Relationship to Patient:	Employment Status:	
Employer:	___ Full Time ___ Part time ___ Retired ___ Self Employed	

PATIENT REGISRATION (CONT) PATIENT NAME:____________________________________

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT FOR PHYSICIAN'S SERVICES

I hereby give consent to **Guam Sleep Center/Gabriele M. Barthlen, M.D.** to provide whatever treatment is deemed necessary.

I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these services.

I request that payment of authorized Medicare and other insurance benefits be made to me or on my behalf to the physician named above for any services furnished me by that physician. This assignment will remain in effect until revoked in writing.

I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

Signature ____ Date ____

Relationship to patient ____________________________________ Witness ____
(Complete Relationship if other than self)

NOTES

-OVER-