PATIENT INFORMATION

Name: ____

Date of birth:__________________________ S.S.#: ______________________________ Sex: Male Female

Address: ____________________________________ City: __________________ State:______ Zip: _______

Best Telephone # (____)__________________ HOME/WORK/MOBILE May we leave a message? YES NO If yes, can it be detailed? YES NO

2nd Telephone # (____)____________________HOME/WORK/MOBILE May we leave a message? YES NO If yes, can it be detailed? YES NO

3rd Telephone # (____)____________________HOME/WORK/MOBILE May we leave a message? YES NO If yes, can it be detailed? YES NO

Name/relationship of nearest friend or relative (not living with you): _____________________________________

Is this contact for emergencies only? YES NO Best telephone # to contact this person: ____________________

What is your occupation: ____

What is your marital status: _______________ If married, name of spouse:_______________________________

Name of Primary Insurance Carrier _______________________ Policy # or SS#:_______________________

Policy holder's name:___________________ Date of birth:_________________________

Name of Secondary Insurance Carrier _______________________ Policy # or SS#:_______________________

Policy holder's name:___________________ Date of birth:_________________________

Referring Doctor/Address: ____ Phone #:_______________________

Please have your insurance card and photo identification available to be copied

MEDICARE AND MEDICAID: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I assign and request that benefits and payments, under the medical insurance program, be made to Ohio Pulmonary & Sleep Consultants, Inc. for any services furnished me by Ohio Pulmonary & Sleep Consultants, Inc.

ALL OTHER INSURANCE: I hereby authorize Ohio Pulmonary & Sleep Consultants, Inc. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to Ohio Pulmonary and Sleep Consultants, Inc. for the next twelve month period.

RELEASE OF RECORDS: I hereby authorize Ohio Pulmonary and Sleep Consultants, Inc. to release any information concerning my illness and treatments to my insurance company(s) and any entity in which Ohio Pulmonary and Sleep Consultants, Inc. holds a confidentiality agreement.

I understand that I am responsible for payment of any charge left unpaid by my insurance or other source. I will uphold any payment schedule agreement negotiated with Ohio Pulmonary & Sleep Consultants, Inc.

Signature:_______________________________________

Date:____

I, ________________________________, acknowledge that I have received a copy of the Privacy Policy of Ohio Pulmonary and Sleep Consultants, Inc dba the Sleep and Breathing Research Institute.

Additionally, I understand that it is my right to choose who can receive my personal information. I hereby give permission to disclose any and all information to the following person(s):

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**Note: Additional, more specific requests must be made in writing to our Privacy Officer.

Signature:____

Date of birth:____

Date:____

Witnessed:____