



Patient Name: _____ Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____ Home Tel: (____) _____ Cell: (____) _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Sex: Male Female Marital Status: Single Married Widowed Divorced Language: English Spanish Other: _____

Race: White Black Asian Other: _____ Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino

Email: _____

Pharmacy Name: _____ Phone: (____) _____

Pri Care Prov: _____ Phone: (____) _____ Fax: (____) _____

Referring Prov: _____ Phone: (____) _____ Fax: (____) _____

Employer: _____ Phone: (____) _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Would you like to designate a personal representative which grants your physician permission to discuss your personal health information (PHI), such as your spouse or other family member? (CIRCLE) YES NO (if yes...additional form required)

Do you have any restrictions on how you would like to be contacted? (CIRCLE) YES NO (if yes...addition form required)

Do you give permission to our physicians to leave messages on your answering machine/voicemail regarding your Personal Health Information (i.e. test results, etc.)? (CIRCLE) YES NO If YES, Phone#: (____) _____

HEALTH INSURANCE: *A photocopy of these assignments shall be valid as the original

*PRIMARY INSURANCE: _____ Policy # _____ Group # _____

Insured's Name: _____ Insured's DOB: ____/____/____

Insured's SS#: _____ - _____ - _____ Relationship to the patient: _____

*SECONDARY INSURANCE: _____ Policy # _____ Group # _____

Insured's Name: _____ Insured's DOB: ____/____/____

Insured's SS#: _____ - _____ - _____ Relationship to the patient: _____

NOTICE TO PATIENTS: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary. I declare that all information presented at date of service is complete and accurate. In the event that the information about the insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize Sleep Medicine Specialists of South Florida, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to Sleep Medicine Specialists of South Florida, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE: _____ DATE: _____

1350 SW 57 Avenue; Suite 210
Miami, FL 33144

777 E. 25 Street; Suite 320
Hialeah, FL 33013

8726 NW 26 Street; Unit # 3
Doral, FL 33172

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