

Please complete the entire form and sign at the  
bottom on the second page.

Patient Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Sex:  Female  Male Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN# : \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Employer: \_\_\_\_\_ Phone#: \_\_\_\_\_

### Responsible Party Information

Same as above

Relationship to Patient:  Spouse  Child  Other \_\_\_\_\_

Resp Part Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex:  Female  Male Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN# : \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Employer: \_\_\_\_\_ Phone#: \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Primary Insurance Information**

Name Of Carrier: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ ID# \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
Last First Middle Initial

Policy Holder's Date Of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Holder's SSN#: \_\_\_\_\_

**Secondary Insurance Information**

Name Of Carrier: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ ID# \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
Last First Middle Initial

Policy Holder's Date Of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Holder's SSN#: \_\_\_\_\_

**\*\*\*\*\* NOTICE \*\*\*\*\***

I understand that the information collected is for billing purposes only and that it is my responsibility to keep Advanced Sleep Disorder Center updated with any changes in my insurance coverage and/or (address, telephone number, ect.) contact status.

I understand that Advanced Sleep Disorder Center,LLC will bill my insurance carrier and that I am responsible for all deductibles, co-payments, and any balance after insurance has paid. I understand that if I do not provide proof of insurance at the time of service, that I will be billed directly and am legally liable for paying the entire amount of my account.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date