PATIENT REGISTRATION

Today's Date:__________________ Home Phone #_________-_________-__________ Cell Phone #_________-________-__________

Patient's Last Name:________________________________ First:___________________________________ Middle Initial:__________

SS #________-_______-_________ Date of Birth________/________/________ ❑Male or ❑Female *Status*: ❑S ❑M ❑D ❑W

Home Address:____ Apartment Number:____________

City:__________________________ State:________ Zip Code:___________ Email address:____________________________________

Occupation:____ Employer Name:____

Employer Address:____ City:_________________ State:_______ Zip Code:__________

Work Phone #_________-_________-__________ Emergency Contact:____

Emergency Phone #__________-_________-__________ Relationship to Patient:____

Referred By:_______________________________________ Primary Care Physician:____

How did you hear about us? ❑Advertisement ❑Employer ❑Friend/Relative ❑Other:_____________________________________

Race: Please mark what best describes you. If more than one, please mark numerically in order.

☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Black/African American

☐ Asian:____ ☐ Native Hawaiian/Other Pacific Islander

☐ Other:____ ☐ Decline

Ethnicity: Do you consider yourself Hispanic/Latino? ❑ Yes ❑ No ❑ Decline

Which **Language** do you speak in your home?____

PRIMARY INSURANCE: Subscriber to Insurance: ❑ Self ❑ Spouse ❑ Parent ❑ Company

Last Name:____ First:____________________________________ Middle:________

Relationship to Patient:____________________________ SS #_________-_________-__________ Date of Birth:________________

Insurance Name:_________________________________ Subscriber ID:___________________________ Group #________________

SECONDARY INSURANCE: Subscriber to Insurance: ❑ Self ❑ Spouse ❑ Parent ❑ Company

Last Name:____ First:____________________________________ Middle:________

Relationship to Patient:____________________________ SS #_________-_________-__________ Date of Birth:________________

Insurance Name:_________________________________ Subscriber ID:___________________________ Group #________________

WORKERS COMPENSATION: **Did you report the injury to your Employer? ❑ Yes ❑ No**

Date of Injury:_______/_______/________ Time:______________ AM/PM Claim Number:_______________________________

Where Injury Occurred:____

Employer Contact:____ Contact Phone #____________-__________-__________

Claims Adjuster:__________________________________ Phone:________-________-________ Fax:_______-_________-_________

Insurance:_____________________________________ Address:____

City:____ State:______________________ Zip Code:_________________________

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying All Care Sleep Center (ACSC) of any changes made to my contact information and/or insurance.

Medication History Consent: I hereby authorize All Care Sleep Center (ACSC) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice. I authorize ACSC to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

__________________ ____

DATE **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**