Confidential

REGISTRATION INFORMATION

Patient Name _____ **Date of Birth** _____

Last First Middle Initial Age _____ Sex ☐ M ☐ F

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell phone** _____ **Work Phone** _____ **Ext** _____

Best time and place to reach you _____ **Email** _____

Marital Status ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

Occupation _____ **Present Employer** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Contact in Emergency/Next of Kin

Name _____ **Relationship** _____

Last First Middle Initial

Home Phone _____ **Cell phone** _____ **Work Phone** _____ **Ext** _____

Social Security ___ ___ ___ ■ ___ ___ ■ ___ ___ ___ ___

Primary Insurance Information

Insurance Company _____

Insurance Company Address _____

Identification # _____ **Group & Policy #** _____

Secondary Insurance Information ☐ None

Insurance Company _____

Insurance Company Address _____

Identification # _____ **Group & Policy #** _____

Physician and Pharmacy

Name of Physician or Individual referring you here _____

Primary Medical Physician _____ **Should we send Sleep Study report to your PMD** ☐ Yes ☐ No

Preferred Pharmacy _____ **Phone** _____

Preferred Lab if any ☐ Lab corp ☐ Qwest ☐ Other _____

Are you able to walk unassisted? ☐ Yes ☐ No **Do you use oxygen at night?** ☐ Yes ☐ No **Do you use CPAP at night?** ☐ Yes ☐ No

What, if any, you take medications to fall asleep?

Have you received services at Trinitas? ☐ Yes ☐ No **If yes When?** _____ **MRNo#** _____

Date test scheduled _____ **Type of Test** ☐NPSG ☐CPAP ☐MSLT

Diagnosis _____ _____ **Weight >300lbs** ☐ Yes ☐ No **Risk of Fall** _____

Insurance Assignment and Release

☐ I certify that I (and or my dependent) have insurance as above and assign directly to Dr. Vipin Garg, MD all Insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signatures on all insurance submissions. The physician may use my health care information or may disclose such information to the various insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable related services.

☐ I request that payment of authorized Medicare benefits or if applicable medigap benefits be made to above physician directly for any services furnished to me by this provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release it to Centers of Medicare Services and Medicaid Services, my medigap insurance and their agents any information needed to determine these benefits or benefits related services.

X_____ _____

Signature of Beneficiary, Guardian or Patient Representative **Date**

_____ _____

Name of Beneficiary, Guardian or Patient Representative **Relationship to Beneficiary**