BAY AREA SLEEP EVALUATION CENTER
Patient Registration

Allergies:_____
Patient Name: Last_____First_____MI_____
SSN:_____DOB:_____ M/F AGE_____M/ S/ D
Address(C/S/Z)_____
Phone #: Home_____Work_____Cell_____
Employer:_____Occupation:_____
Employer Address(C/S/Z):_____
Special Needs:_____

Spouse Name: Last:_____First:_____MI:_____
SSN:_____DOB:_____Age:_____
Phone # Home:_____Work:_____Cell:_____
Employer:_____

IN CASE OF EMERGENCY CONTACT:_____
Phone#:Home:_____Work:_____Cell:_____
Relationship:_____

Primary Insurance Name:_____
Address: (C/S/Z):_____
Subscriber to Policy: Name:_____Relationship:_____
Insurance Phone Number:_____Policy Number:_____
Deductible:_____Coverage:_____Estimated Due:_____
Out of Network Deductible:_____Coverage:_____Met:_____

Secondary Insurance Name:_____
Address (C/S/Z):_____
Subscriber:_____Relationship to Patient:_____
Insurance Phone #:_____Policy Number:_____
Deductible:_____Coverage:_____Estimated Due:_____

Authorization to pay benefits and release information

I hereby authorize Bay Area Sleep Evaluation Center to receive payment of insurance benefits for the procedures performed. I also understand that a copy of this authorization can be used and will be valid as my original signature. I understand that I am financially responsible for all charges, including fees of the reading physician, whether or not paid by my insurance. I hereby authorize Bay Area Sleep Evaluation Center to release any information necessary to the insurance company as well as the referring and/or any physician acquired in the course of any examination.

_____ _____
Patient Signature or Responsible Party Date