New Patient Registration

PATIENT INFORMATION

Last Name: _____ First Name: _____ M. Initial: _____

DOB: _____ Sex: ☐ Female ☐ Male Social Security Number: _____-_____-_____

Marital Status: _____ email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

PHARMACY NAME & PHONE NUMBER: _____

PRIMARY CARE PROVIDER: _____ **REFERRING PROVIDER:** _____

PARENT OR GUARDIAN INFORMATION *(Only fill out if the patient is under the age of 18)*

Last Name: _____ First Name: _____ M. Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Social Security Number: _____-_____-_____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

EMPLOYER: _____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: _____ Subscriber ID: _____

POLICY HOLDER NAME *(if other than patient)*: _____

DOB: _____ Sex: ☐ Female ☐ Male Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____ Subscriber ID: _____

POLICY HOLDER NAME *(if other than patient)*: _____

DOB: _____ Sex: ☐ Female ☐ Male Relationship to Patient: _____

The information below is being collected pursuant to the requirements of the TN Department of Health in compliance with Tennessee state law.

RACE: ☐ White ☐ Black ☐ American Indian ☐ Eskimo or Aleut ☐ Asian or Pacific Islander ☐ Other Race ☐ Unknown Race

ETHNICITY: ☐ Hispanic Origin ☐ Not Hispanic Origin

Please check the appropriate box in answer to the following question. Have you executed an Advanced Health Care Directive, A Living Will or a Power of Attorney? ☐ Yes ☐ No

DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO? NAME: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

Essential Sleep
CONSULTANTS

Roxanne Valentino, MD
113B Maple Row Boulevard • Hendersonville, TN 37075 • **p:** 615.265.8776 • **f:** 615.258.9620 • MyEssentialSleep.com

Release Of Medical Information

NAME *(Please print)*: _____ DOB: _____

By Signing Below, I Authorize Essential Sleep Consultants To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

All patients 18 and over should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members.

Do you have a Living Will or Power of Attorney? ☐ YES ☐ NO

We ask that if you have any change in this request, that you please inform the receptionist.

Essential Sleep Consultants may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____ DATE _____

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

We charge a $20 flat rate for 1-5 pages plus .50 per additional page and postage.

I understand that Essential Sleep Consultants will ask for identification of the person picking up patient medical information or products.

Please list all other providers who provide care to you along with their specialty: _____

_____

_____

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