

# 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: \_\_\_\_\_



# 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CHILDREN	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
IN-LAWS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WORK	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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

**RELATIONSHIP**

SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVER	<input type="checkbox"/> YES	<input type="checkbox"/> 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:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

