Sleep 360 Sleep Diagnostic Center

Complete Solution to your Sleep Problems

10601 Pecan Park Blvd. Suite 203, Austin, Texas 78750
Ph: (512)-810-0360 Fax: (512)-918-0361

Patient Record Information

Please Complete Each Section

Patient Information:
Patient Name: Last: -------------------------------------- First: -------------------- MI: ----
DOB: ----------------------- Marital Status: ------------------ Gender: M / F (circle one)
Address: --
City: ------------------------------- State: -------------------------------- Zip: -----------------
Home Ph No: ( )---------------------------- Cell Ph No: ( )-------------------------
Employer: --- Work Ph No: ----------------------------
Address: --
City: ----------------------------- State: -------------------------------- Zip: --------------------
DL # --------------------------------------- State Issued: --------------SSN:--------------------

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Emergency Information:
Name: --- Relationship: --------------------
Address: --
City: ------------------------------ State: ----------------------- Zip: ---------------------------
Home Ph # ( )---------------------------------- Alternate # ( )--------------------

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Insurance Information: *Avoid if card has been copied*
Name of the Insurance Company: ---
Policy Holder's Name: -- SSN: ---------------------------
Policy/ID # -- Group # ----------------------------------
Address: --- City/State: ------------------ Zip:--------

Guarantor Information:
Name: -- Relationship: --------------------------
SSN: --------------------------------- DL # ----------------------------- State Issued: ----------
Address: --
City: -------------------------------- State: --------------------------- Zip: --------------------
Home Ph # ( )--------------------------------- Cell Ph # ( )--------------------------
Employer: --- Occupation: ----------------------------
Address: -- City/ State: --------------------------
Zip: --------------------------- Work Ph # ( )--

I authorize Sleep 360 Sleep Diagnostic Center physicians and / or Physician Assistant to furnish my information to insurance company in order to process my claim. I grant permission to release my medical records if necessary. I understand that I am responsible for my expenses, unless an assignment is accepted and my insurance coverage is contract between the insurance company and myself. I understand that payment is expected at the time of service, unless prior arrangements have been made. I do agree for my insurance money to go to Sleep 360 Sleep Diagnostic Center Physicians and / or Physician Assistants, unless I have paid my balance in full at the time of service.
Sleep 360 Sleep Diagnostic Center is not responsible for expense of the sleep study.

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Signature of patient / Guarantor **Date**