

PHONE
MIAMI 305.666.8800
CENT FL 407.249.1002
NASH 615-885-9750

SLEEP CARE SOLUTIONS, LLC
&
CARE SOLUTIONS, INC

FAX
MIAMI 305.666.8801
CENT FL 407.249.1005
NASH 615.885.9751

PATIENT REGISTRATION FORM

PATIENT INFORMATION

DATE _____

NAME: _____ I PREFER TO BE CALLED: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIPCODE: _____

PHONE: _____ WORK PHONE: _____ CELL: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

CHECK APPROPRIATE BOX:

___ MINOR ___ SINGLE ___ MARRIED ___ WIDOWED ___ SEPARATED ___ DIVORCED

EMPLOYER: _____ EMPLOYER'S PHONE: _____

IF STUDENT, NAME OF
SCHOOL: _____

EMAIL ADDRESS: _____

SPOUSE/PARENT'S
NAME: _____ EMPLOYER: _____

SPOUSE/PARENT'S WORK PHONE: _____

PERSON TO CONTACT IN CASE OF

EMERGENCY: _____ **PHONE:** _____

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT: ___ SELF ___ SPOUSE ___ PARENT ___ OTHER _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

PHONE: _____ WORK PHONE: _____ CELL: _____

SOCIAL SECURITY #: _____ EMPLOYER: _____

INSURANCE INFORMATION

NAME OF INSURED: _____ DOB: _____ RELATION: _____

SSN: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

PHONE: _____

INSURANCE COMPANY: _____ ID#: _____

GROUP#: _____ INS. CO. PHONE#: _____

INS. CO. ADDRESS: _____

*****DO YOU HAVE ANY ADDITIONAL INSURANCE? _____ YES _____ NO*****

IF YES, PLEASE COMPLETE THE FOLLOWING

NAME OF INSURED: _____ DOB: _____ RELATION: _____

SSN: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

PHONE: _____

INSURANCE COMPANY: _____ ID#: _____

GROUP#: _____ INS. CO. PHONE#: _____

INS. CO. ADDRESS: _____