



Medstar #

Date: _____ Referring Doctor: _____ Phone # _____

*******Patients Information*******
*******Please Fill Out Completely and Clearly*******

Patient's Full Name: _____ DOB: _____ Age: _____ Sex: _____

Home Address: _____

Mailing Address (If different from Above): _____ Home# _____

Pediatrician Name (PCP) _____ Office# _____ Fax# _____

Pediatrician Address (PCP): _____

Parents Information

Mom's Name : _____ DOB _____ SS# _____

Mothers Cell # _____ Work# _____ Occupation _____

Father's Name: _____ DOB _____ SS# _____

Father's Cell # _____ Work# _____ Occupation _____

E-Mail Address: _____

Primary Policy Holder Information

Policy Holder: _____ DOB: _____ Age: _____ Sex: _____

Relationship to Patient: _____ SS #: _____

Address (If different from patient): _____ Phone# _____

*** **CONTINUED ON THE NEXT PAGE** ***

Employer and Address: _____ Work # _____

Primary Insurance: _____ Policy #: _____ Group # _____

ADDRESS TO MAIL CLAIMS: _____

Phone # for Benefits : _____

Secondary Policy Holder Information

Secondary Insurance: _____ Policy#: _____ Group#: _____

Guarantor's Name: _____ Guarantor's DOB: _____ Age: _____ Sex: _____

Relationship to Patient: _____ Guarantor's SS #: _____

Guarantor's Address (If different from patient): _____

Guarantor's Phone: _____ Guarantor's Work #: _____

Guarantor's Employer and Address: _____

Emergency Contact (NOT PARENTS)

Contact Name: _____ Phone #: _____ Cell #: _____

Relationship _____

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the facility. I understand that I am financially responsible for any remaining balance. I also authorize Pediatric Sleep Institute, LP to release any information required to process my claims.

*******The procedures performed today are subject to a technical component and the interpretation will be billed separately by the physicians private office.*******

Parent/Guardian Signature: _____

Date: _____



I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Pediatric Sleep Institute with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Printed Patient's Name

Patient's Signature or Representative Signature and Relationship

Date

Authorized Facility Signature