Ed Charnock, MD, FAASM
Jack Gardner, MD, FCCP

Accredited by the American Academy of Sleep Medicine

Patient Information Form

NAME (Last) _____ **(First)** _____ **(MI)** _____ **Age**_____

Street Address _____ **Apt #** _____ **Sex F / M**

City _____ **State** _____ **Zip** _____

Hm Phone (_____**)** _____ **Wk Phone (**_____**)** _____

Cell Phone (_____**)** _____ **Email Address** _____

Date of Birth _____ **Social Security Number** _____

Employer _____ **Occupation** _____

Referring Physician _____ **Phone (**_____**)** _____

Referring Physician's Address _____

Spouse's Name _____

Spouse's Social Security # _____ **Spouse's Date of Birth** _____

Spouse's Employer _____ **Spouse's Work #** _____

Emergency Contact _____ **Phone #** _____

PATIENT INSURANCE INFORMATION

Primary Insurance Company _____ **Group #** _____

Policy Holder SELF __ SPOUSE __ PARENT __ Insurance ID # _____ **DOB:** _____

Policy Holder Name _____ **Social Security #**_____

Claims Mailing Address _____ **Phone #** _____

Secondary Insurance Company _____ **Group #** _____

Policy Holder SELF _____ **SPOUSE** _____ **PARENT** _____ **Insurance ID #** _____

Policy Holder Name _____

Policy Holder Social Security #_____ **Policy Holder Date of Birth** _____

Claims Mailing Address _____ **Phone #** _____

I hereby assign all medical and/or surgical benefits to CNS Sleep Disorders Centers. I understand that I am financially responsible for all charges, whether paid or not paid by my insurance company. I also authorize the physician to release any medical information and records, if needed, to assist reimbursement from the insurance company. I authorize CNS Sleep Disorders Centers to provide medical treatment.

Patient Signature _____ **Date** _____

Responsible Party Signature _____ **Date** _____