Iowa Sleep

Patient Registration (please print)

Name: _____ SSN:_____ Marital Status: M S W D

Race: _____ Ethnicity: _____

Address: _____ City: _____State: ____ Zip: _____

Home phone: _____ Sex: M F Birthdate: _____

Cell phone: _____ e-mail _____

Patient Employer: _____ Work phone: (____) _____

Bill To

Responsible Party: _____ Relation to Patient: _____

Address: _____ City: _____State: _____ Zip: _____

Home phone: _____SSN: _____ Birthdate: _____

Insurance Information

Primary Insurance:_____Policy #_____Group # _____

Subscriber Name: _____ SSN: _____ Birthdate: _____

Secondary Insurance: _____ Policy # _____ Group# _____

Subscriber Name: _____ SSN: _____ Birthdate: _____

In case of emergency, whom should we contact? _____ Phone: _____

Your Pharmacy Name: _____ Phone: _____

Referring Physician (if any): _____ Phone: _____

Note: It is the responsibility of the patient to be aware of health insurance benefits including, but not limited to, co-pays, deductibles, and network participation.

Assignment of Insurance Benefits:

I, the undersigned hereby authorize the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents. I agree that my signature on this document authorizes my physician and/or his employees to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I had personally signed the particular claim.

I, the undersigned hereby authorize the above named insurance company (s) to pay and hereby assign directly to Iowa Sleep all benefits, if any, for services rendered by staff at the Iowa Sleep. I further acknowledge that any insurance benefits when received by and paid to the Iowa Sleep will be credited to my account, in accordance with the above said assignment.

Authorized signature of subscriber:_____ Date: _____

Revised 5/22/2014