Snoring & Sleep Apnea Treatment Centre

PATIENT INFORMATION

☐ MR ☐ MRS ☐ DR ☐ MS ☐ MISS | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐WIDOWED

PATIENT'S NAME:____

AGE:______________ DATE OF BIRTH:__________________ ☐ MALE ☐ FEMALE

ADDRESS:____

CITY, PROVINCE, POSTAL CODE:______________________________________

HOME PHONE #:__________________________ BUSINESS or CELL #:__________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

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INSURANCE INFORMATION: We will gladly provide you with insurance pre-determinations, claims and any necessary information for each visit. Depending on the insurance company we may, or may not be permitted to take assignment of benefits. Please let us know if you have any questions.

INSURANCE COMPANY:____

PLAN/GROUP#:_____________________ PATIENT ID #:__________________________

INSURANCE HOLDER'S NAME:______________________________________

INSURANCE HOLDER'S DATE OF BIRTH:______________________________

EMPLOYER'S NAME:____

I certify that the above information is correct to the best of my knowledge.

PATIENT SIGNATURE____________________________ DATE:_______________________