

Sleep and Wellness Medical Associates Patient Registration

Today's Date:			
PATIENT INFORMATION			
Name:			
Birth Date:	Age:	Sex:	Marital Status:
Street Address, City, State, Zip:			
Social Security No.:	Home Phone:	Work Phone:	Cell Phone:
Employer:		Occupation:	
Email:			
INSURANCE INFORMATION			
Person Responsible for Bill:			
Primary Insurance:		ID No.:	
Subscriber's Name, DOB, SSN:			
Effective Date:		Group No.:	
Secondary Insurance:		ID No.:	
Subscriber's Name:		Group No.:	
IN CASE OF EMERGENCY			
Name:			
Home Phone:		Cell Phone:	
Relation:			
<p>ASSIGNMENT OF BENEFITS I hereby authorize direct payment of medical benefits to Sleep and Wellness Medical Associates for services rendered by Dr. Siddique in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.</p> <p>AUTHORIZATION TO RELEASE INFORMATION I hereby authorize Dr. Siddique to release any medical or incidental information that may be necessary for either medical or in processing applications for financial benefits. I certify that the information given to me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.</p>			
Patient/Guardian Signature:			Date: