SLEEP MEDICINE SPECIALISTS OF SOUTH FLORIDA

Patient Name: _____ ***Social Security Number:*** _____ - _____ - _____

Date of Birth: _____ / _____ / _____ ***Home Tel:*** (_____) _____ ***Cell:*** (_____) _____

Address: _____ ***Apt/Unit:*** _____

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

Sex: ○Male ○Female ***Marital Status:*** ○Single ○Married ○Widowed ○Divorced ***Language:*** ○English ○Spanish ○Other: _____

Race: ○White ○Black ○Asian ○Other: _____ ***Ethnicity:*** ○ Hispanic/Latino ○ Non-Hispanic/Non-Latino

Email: _____

Pharmacy Name: _____ ***Phone:*** (_____) _____

Pri Care Prov: _____ ***Phone:*** (_____) _____ ***Fax:*** (_____) _____

Referring Prov: _____ ***Phone:*** (_____) _____ ***Fax:*** (_____) _____

Employer: _____ ***Phone:*** (_____) _____ ***Occupation:*** _____

RESPONSIBLE PARTY:

Guardian Name: _____ ***D.O.B:*** _____ / _____ / _____ ***Patient Lives With:*** _____

Mom's Name: _____ ***Social Security Number:*** _____ - _____ - _____
Address (if different): _____ ***City:*** _____ **ST:** _____ ***Zip:*** _____
D.O.B: _____ / _____ / _____ ***Email:*** _____
Employer: _____ ***Work #:*** (_____) _____ ***Cell #:*** (_____) _____

Dad's Name: _____ ***Social Security Number:*** _____ - _____ - _____
Address (if different): _____ ***City:*** _____ ***ST:*** _____ ***Zip:*** _____
D.O.B: _____ / _____ / _____ ***Email:*** _____
Employer: _____ ***Work #:*** (_____) _____ ***Cell #:*** (_____) _____

HEALTH INSURANCE: ***A photocopy of these assignments shall be valid as the original***

****PRIMARY INSURANCE:*** _____ ***Policy #*** _____ ***Group #*** _____

Insured's Name: _____ ***Insured's DOB***: _____ / _____ / _____

Insured's SS#: _____ - _____ - _____ ***Relationship to the patient***: _____

****SECONDARY INSURANCE:*** _____ ***Policy #*** _____ ***Group #*** _____

Insured's Name: _____ ***Insured's DOB***: _____ / _____ / _____

Insured's SS#: _____ - _____ - _____ ***Relationship to the patient***: _____

***NOTICE TO PATIENTS*:** Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary. I declare that all information presented at date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize Sleep Medicine Specialists of South Florida, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to Sleep Medicine Specialists of South Florida, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE OF GUARDIAN/RESPONSIBLE PARTY: _____ ***DATE:*** _____

1350 SW 57 Avenue; Suite 210
Miami, FL 33144

777 E. 25 Street; Suite 320
Hialeah, FL 33013

8726 NW 26 Street; Unit # 3
Doral, FL 33172

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