Georgetown
Sleep Equipment & Supplies

Registration Form

Even though we will copy your insurance cards, Please complete all of the information requested.

HOW DID YOU HEAR ABOUT US?_____

PATIENT INFORMATION

Patient's Name: _____ Social Security #:_____
Last, First, Middle

Date of Birth (MM/DD/YY) ____/____/____ Age:____ Marital Status:_____Driver's License:_____

Home Address: _____
City, State, Zip

Home Phone: _____Work Phone:_____Other/Cell:_____

Employer:_____ Work Address:_____
City, State, Zip

Email: _____ Do we have permission to e-mail you? ❑ Yes ❑ No

INSURANCE INFORMATION

Primary Insurance: _____ ❑HMO ❑PPO ❑Other Phone:_____Group #:_____

*Subscriber's name:*_____*Subscriber's Date of Birth* ____/____/____ ID#:_____

Subscriber's Employer: (❑Same as above)_____Work Phone:_____

Subscriber SSN:_____Claim's Address:_____
City, State, Zip

Secondary Insurance: _____ ❑HMO ❑PPO ❑Other Phone:_____Group #:_____

*Subscriber's name:*_____*Subscriber's Date of Birth* ____/____/____ ID#:_____

Subscriber's Employer: (❑Same as above)_____Work Phone:_____

Subscriber SSN:_____Claim's Address:_____
City, State, Zip

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Guarantor's Information:
Name:_____ Social Security #:_____
Last, First, Middle

Date of Birth (MM/DD/YY) ____/____/____ Age:____ Marital Status:_____Driver's License:_____

Home Address: _____
City, State, Zip

Home Phone: _____Work Phone:_____Other/Cell:_____

Employer:_____ Work Address:_____
City, State, Zip

I, the undersigned, certify that I (or my dependant) have insurance coverage as indicated above and assign directly to Georgetown Sleep Equipment and Supplies all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____ _____
Patient/Guardian (If patient is a minor) signature **Relationship** **Date**