Houston
SLEEP AND NARCOLEPSY

www.sleepandnarcolepsy.com
Tel: 713-465-9282
Fax: 877-358-9344

Patient Registration

LAST NAME	FIRST NAME	MIDDLE

HOME STREET ADDRESS	CITY	STATE	ZIP CODE

DOB (M/D/YEAR)	SS# (LAST 4)	DL#	SEX	MARITAL STATUS

CELL PHONE	HOME PHONE	WORK PHONE	EMAIL ADDRESS

EMPLOYER	OCCUPATION

EMERGENCY CONTACT 1	RELATION TO PATIENT	CELL / HOME / WORK PHONE
EMERGENCY CONTACT 2	RELATION TO PATIENT	CELL / HOME / WORK PHONE

RACE

- ☐ White American
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ American Indian and Alaska Native
- ☐ Other:

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

SPOUSE NAME	CELL / HOME / WORK PHONE	EMAIL ADDRESS

IF MINOR, MOTHER'S NAME	CELL PHONE	WORK PHONE	EMAIL ADDRESS
IF MINOR, FATHER'S NAME	CELL PHONE	WORK PHONE	EMAIL ADDRESS

HOW DID YOU HEAR ABOUT US?	REFERRAL NAME

GUARANTOR INFORMATION (Person Financially Responsible)

NAME	RELATIONSHIP TO PATIENT

HOME STREET ADDRESS	CITY	STATE	ZIP CODE
DOB (M/D/YEAR)	HOME PHONE	WORK PHONE	CELL PHONE
EMPLOYER NAME	CITY	STATE	ZIP CODE

INSURANCE INFORMATION

INSURANCE NAME	MAIN PHONE
POLICY HOLDER NAME	RELATION TO PATIENT
SUBSCRIBER ID #	GROUP #

I, the insured person for this account, do assign the collection of benefits to Houston Sleep and Narcolepsy PLLC. I give permission to release medical information needed to process medical claims. I understand that Houston Sleep and Narcolepsy PLLC will attempt to collect payment from my insurance company; however, I am ultimately responsible for the payments on this account. Any balance unpaid by my insurance company after 60 days of filing can be billed to me for payment.

PRINTED NAME OF PATIENT/PARENT/LEGAL GUARDIAN	SIGNATURE	DATE (MTH/DAY/YEAR)