Emerald Sleep Disorders Center

Dainis Irbe, MD - BOARD CERTIFIED IN NEUROLOGY & SLEEP DISORDERS
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How did you hear about us: Doctor-PCP ☐ Radio ☐ Newspaper ☐ TV ☐ Friend/Family ☐ Web Site ☐

A. Name_____ Social Security #_____-_____-_____
Last First Middle
Status (check one): ☐Single ☐Married ☐Divorced ☐Separated ☐Partner Birth date: _____
Do you speak English: ☐Yes ☐No
Gender ☐M ☐F Race/Ethnicity _____ Preferred Language _____

Home Address_____ Home Phone: (____) _____-_____
Street City State Zip Code
Mailing Address_____ Email_____

Employer_____ Work Phone: (____) _____-_____

Spouse/Parent _____ DOB:_____ SS # _____-_____-_____

Address_____ Home Phone: (____) _____-_____
Street City State Zip Code

Employer _____Work Phone: (____) _____-_____

B. ***If someone other than the PATIENT is responsible for payment, complete the following:***

Name of Guarantor_____ SS#_____-_____-_____ DOB:_____
Address_____ Home Phone: (____) _____-_____
Employer_____Work Phone: (____) _____-_____
Relationship to Patient:_____

C. In case of EMERGENCY:
Relative to contact (other than spouse) _____ Phone: (____) _____-_____
Other person to contact (not a relative) _____ Phone: (____) _____-_____

D. How do you intend to pay? Cash____ Check ____ Insurance ____ Medicare ____ OHP ____ Other _____

Primary Insurance Co. _____ Policy #_____Group#_____
Address:_____ Phone: (_____) _____-_____
Name of Insured:_____ DOB:_____

*Secondary Insurance Co.*_____ Policy #_____Group #_____
Address:_____ Phone: (_____) _____-_____
Name of Insured:_____ DOB:_____

E. Reason for visit: ☐ Illness/Injury ☐ Job related ☐ Auto accident ☐Other _____ Date onset _____

Verified (initial & date): _____: _____: _____: _____: _____