



# OhioHealth Sleep Services

**PATIENT INFORMATION (PLEASE PRINT / PRESS FIRMLY)** New     Update

Full Name \_\_\_\_\_  
Last First MI  
 Home Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex  Male  Female  
 Marital Status  Single  Married  Widowed  Legally Separated  Other  
 Employment  Full Time  Part Time  Retired Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION (Please provide the receptionist with your card to photocopy)**

Primary Insurance Name: \_\_\_\_\_ Copay Amount \$ \_\_\_\_\_  
 Policy # / ID \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber (If not patient)  
 Name \_\_\_\_\_  
Last First MI  
 Social Security # \_\_\_\_\_ Relationship to Patient  Spouse  Dependant Effective Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Sex  Male  Female  
 Secondary Insurance Name \_\_\_\_\_ Copay Amount \$ \_\_\_\_\_  
 Policy # / ID \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Subscriber DOB \_\_\_\_\_ Sex  Male  Female  
 Subscriber SS# \_\_\_\_\_ Relationship to Patient  Self  Dependant Effective Date \_\_\_\_\_

**EMERGENCY CONTACT Nearest Friend or Relative not living in your household**

Name \_\_\_\_\_ Home phone \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Work phone \_\_\_\_\_

As a patient you have certain responsibilities for your care. Those responsibilities include:

- Providing current, accurate billing information at all visits.
- Provide physician with complete medical history.
- Being aware of which benefits your insurance does and does not cover.
- Failure to cancel appointment 24 hours in advance may result in a fee.

I hereby authorize my insurance benefits to be paid directly to the OhioHealth Sleep Services, LLC and I am financially responsible for any balance due. I authorize OhioHealth Sleep Services, LLC to release any information necessary to process an insurance claim.

My signature acknowledges understanding and consent to all of the above information.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Parent/Guardian if signing for minor