SUPERIOR SLEEP AND WELLNESS NEW PATIENT FORM:

PATIENT INFORMATION

First Name: ___________________________ Last Name: ___________________________ Middle Initial: ______

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Best Time to Call: Morning/Afternoon/Evening, Call: Home/Cell/Work Email: ___________________________

DOB: ______/______/______ SSN: ____________________ Height: _____________ Weight: _____________

Address: ____________________________________ City: _____________________ State: __________ Zip: _____________

Marital Status: S/M/D/W Emergency Contact: ___________________________ Relationship: ________________

Phone: ________________________ Referred By: ____

EMPLOYER INFORMATION:

Employer: ____ Phone: __________________________

Address: ____________________________________ City: _____________________ State: __________ Zip: _____________

INSURANCE INFORMATION:

Insurance Company Name: ____

Group Policy/TWCC #: ________________ Group Name: __________________ Insurance ID#: ___________________

Plan Name: ____________________ Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company

First Name: ___________________________ Last Name: ___________________________ Middle Initial: ______

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: __________________________

DOB: ______/______/______ Email: ___________________________ Employed By: ___________________________

Address: ____________________________________ City: _____________________ State: __________ Zip: _____________

SECONDARY INSURANCE INFORMATION: Insurance Company Name: ___________________________________

Group Policy/TWCC #: ________________ Group Name: __________________ Insurance ID#: ___________________

Plan Name: ____________________ Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company

IF other than self, please provide the insured person DOB: ______/______/______

MEDICAL CONTACTS:

Superior Sleep and Wellness coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers:

PRIMARY CARE DOCTOR: ____ PHONE: _________________________

ENT: ____ PHONE: _________________________

SLEEP DOCTOR: ____ PHONE: _________________________

DENTIST: ____ PHONE: _________________________

OTHER DOCTOR: ____ PHONE: _________________________

OTHER DOCTOR: ____ PHONE: _________________________

I CERTIFY THIS INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature: ____ Date: _________________________