EVERYTHING SLEEP — IDAHO —

PLEASE READ

- Information areas marked with an * are required.
- Photo ID and insurance cards are required at appointment time.
- Copay or Co-insurance payment is expected at appointment time. (Doctor's office only)

PATIENT INFORMATION

*Patient Name:_____

*Complete Address:_____
*Date of birth:_____Marital Status: Choose One
***Social Security #:**_____
*Home Phone:_____Cell Phone:_____
Employer:_____Work phone: _____

Email address: _____Patient Portal? Choose One
Primary Care Provider: _____

Emergency Contact:_____
Relationship to patient:_____
Emergency contact phone #:_____

How did you hear about us?
Choose One

Pharmacy Name:_____
Pharmacy Location (cross streets):_____

****If patient is a minor, please complete guarantor information below:**

*Guarantor Name:_____
*Guarantor Address (if different from above): _____
*Guarantor date of birth: _____*Guarantor Social Security #:_____

Preferred language: Choose One

Race: Choose One

Ethnicity: Choose One

By signing below, you are certifying that all information is true and accurate to the best of your knowledge.

Patient/Guarantor Signature:_____Date:_____
Relationship to patient:_____