Desert Pulmonary & Sleep Consultants, PLC

Main Office
3303 East Baseline Road, Suite 208
Gilbert, AZ 85234
480-962-1650(P) 480-962-1883(FAX)

Sleep and Diagnostic Center
2730 South Val Vista Drive, Suite 155
Gilbert, AZ 85295
480-917-1996(P) 480-917-3960(FAX)

Patient Registration Form

Patient Name:_____

Billing Address:_____ City, State, Zip:_____

Permanent Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Sex: *M F* Age: _____

Birthdate:_____ Relationship to Patient: *Self Spouse Child Other*

Employer:_____ *Retired* Employer Phone *#:*_____

Referring Doctor Name & Phone #:_____

(Or, how did you hear about us?)_____

Primary Care Doctor Name & Phone #:_____

Spouse or Nearest Relative Name & Phone #:_____

Emergency Contact Name & Phone #:_____

Insurance Information

Primary Insurance:
Insurance Co. Name:_____

Ins. Co. Address:_____

Policy Holder Name:_____

Relationship to Patient: *Self Spouse Child Other*

Employer:_____

Policy No.:_____

Group/Claim No.:_____

Policy Holder Sex: *M or F* Birthdate:_____

Secondary Insurance:
Insurance Co. Name:_____

Ins. Co. Address:_____

Policy Holder Name:_____

Relationship to Patient: *Self Spouse Child Other*

Employer:_____

Policy No.:_____

Group/Claim No.:_____

Policy Holder Sex: *M or F* Birthdate:_____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (Patient or parent, if minor):_____ **DATE:**_____