WakeSleep Sleep Disorders Center

3100 Duraleigh Rd; Suite 302
Raleigh, NC 27612
Phone: 919-645-9280
Fax: 919-208-2149

PATIENT INFORMATION FORM

Name_____ M / F
Last *First* *Middle* *(Circle One)*

Mailing Address:_____
Address *City* *State* *Zip*

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Date of Birth:_____ SS#_____

Marital Status: Single / Married / Widowed / Divorced *(please circle one)*

Primary Care Physician _____

Referring Physician _____

Insurance Information:
Relationship to Patient to Insured _____Self _____Spouse _____Child _____ Other *(explain)*

Policy Holder:_____

Date of Birth of Policy Holder: _____ SS# of Policy Holder:_____

Policy Holders Employer: _____ Phone ( )_____

Secondary Information:

Secondary Policy Holder:_____

Date of Birth of Policy Holder: _____ SS# of Policy Holder:_____

Policy Holders Employer: _____ Phone ( )_____

Emergency Contact_____ **Relation**_____

Phone Number of Contact:_____

Permission to Leave Message: Home: Yes / No Work: Yes / No Cell: Yes / No

Authorization to release Information to: Name_____ Relationship_____

Phone_____

I understand and agree that (regardless of my insurance status), I am responsible for the balance of my account. I have read the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify WakeSleep of any changes to my health status or the above information.

Signature:_____ Date:_____

Wake Sleep