# MID-WEST CENTER FOR SLEEP DISORDERS

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PLEASE PRINT

## PATIENT INFORMATION FORM

DATE: _______________

LAST NAME | FIRST NAME | MIDDLE/MAIDEN | CHART#

SEX | BIRTHDATE | SOCIAL SECURITY # | PATIENT EMPLOYER

STREET ADDRESS/ APT# | CITY | STATE | ZIP CODE

HOME # | WORK # | EXT. | REFERRING DOCTOR

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

PRIMARY CARE DOCTOR | ADDRESS | TELEPHONE #

SPOUSE'S NAME | SS# | EMPLOYMENT | WORK#

## INSURANCE

PRIMARY INS. CO | SUBSCRIBERS NAME | SS#

SUBSCRIBER IDENTIFICATION | GROUP NUMBER | DOB | SUBSCRIBERS EMPLOYER

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

SECONDARY INS. CO | SUBSCRIBERS NAME | SS#

SUBSCRIBER IDENTIFICATION | GROUP NUMBER | DOB | SUBSCRIBERS EMPLOYER

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

## Responsible Person for Account of Patient Under 18

NAME *(Please specify relationship to patient.)* | SS# | HOME PHONE # | WORK PHONE #

## If condition is related to Workman's Compensation, fill out the information below:

EMPLOYER | DATE OF ACCIDENT

PERSON TO CONTACT FOR VERIFICATION | PHONE NUMBER

GIVE BRIEF DESCRIPTION OF ACCIDENT OR RELATED INJURY: ______________________________

Use reverse side if additional is required.

**Assignment of Benefits:** In consideration of the services provided to me, I hereby assign and transfer to Dr. Gupta, Dr. Gera, Dr. Abbasi, Dr. Kashyap and Mid-West Center for Sleep Disorders, all medical provider benefits payable and any related rights existing under my insurance policies (but not to exceed the amount of professional charges for services rendered). I authorize and direct my insurance company to pay all such benefits directly to Mid-West Center For Sleep Disorders. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company such as deductibles, co-payments, coinsurance and charges for non-covered services.

**Authorization of Release Claims Information**: I hereby authorize Mid-West Center for Sleep Disorders, its employees and agents, to release and disclose all information that has been and that will be received, recorded, or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize Mid-West Center for Sleep Disorders, its employees and agents to act on my behalf in completing claims.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE *(Please specify relationship to patient.)* | DATE

3937 Patient Care Drive, Suite 102 Lansing, MI 48911 Phone: (517) 887-6733 Fax: (517) 887-6736
10415 E. Grand River Rd, Ste 500 Brighton, MI 48116 Phone: (810) 225-7595 Fax: (810) 225-7597