Sound A Sleep Lab
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Patient Profile (Demographics)

Patient Name: First: ____________________________ Middle Int. _____ Last: ________________________________

Address: ____City: _________________ State: ______ Zip: ________

Cell Ph: ______________________ Work Ph: _______________________Home Ph: ______________________

Email (Print legibly): ____________________________________

Height: ____ Ft. ____ In. Weight: ______ lbs. Age: _____ Date of Birth: _____________ Sex: M ___ F ___

Primary Insurance:_________________________________   Secondary Insurance:_______________________________

Cardholder Name:____________________________ Cardholder DOB: ________ Phone: _______________

Cardholder Address(if different): ____

Emergency Contact: ____ Phone: ___________________________

Referring Provider: ____________________________ Primary Care Provider**:** ______________________________

PHARMACY & LOCATION (Street Name): ____

Check List of Medical Problems, if any:

Diabetic____ Heart Disease ____ Hypertension ____ Afib ___ Pacemaker ___CHF ___ COPD ____ Emphysema____

Memory Loss____ Seizure ___ MS___ TIA ___ Stroke ___ Insomnia ___ Chronic Pain ___ Chronic Fatigue ___

Fibromyalgia ___ Depression ___ Anxiety ___ ADD ___ ADHD ___ PTSD ___ Daytime Sleepiness ___

Other ____________________

List any Current Medications:
____
____
____

Please list all known DRUG ALLERGIES: ____

Do you Smoke: YES or NO

I authorize the release of any medical information to process my insurance claim and authorize payment of medical benefits to my doctor for services rendered. I also authorize the use of photographs for medical purposes. I understand that payment is expected when services are rendered including co-payments from insurance companies.

Signature ____ Date______________