

Medina Dental Sleep Solutions-New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: _____
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
The best time to contact me is: Morning Mid-Day Evening on Home phone Cell phone Work phone
Email Address _____ Would you like to receive our e-newsletter? Yes No
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth (M/D/Y): ____/____/____ Gender: M F Social Security Number (SSN): _____
Height: Feet ____ Inches ____ Weight (lbs): ____ Marital Status: Married Single Life Partner Minor
Spouse or Parent/Guardian (if minor) Name: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
REFERRED BY: _____

Employer Information

Employer: _____ Phone: (____) _____ Fax: (____) _____
Address: _____ City: _____ State: _____ Zip: _____

Health Insurance Information

Patient's Relationship to Primary Insured: Self Spouse Child Other
Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____/____/____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address _____ City _____ State: _____ Zip _____
Phone: (____) _____ Fax: (____) _____ Email: _____
Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? YES NO IF **YES**, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured: Self Spouse Child Other
Name of Insured (First, MI, Last): _____ Insured DOB ____/____/____
Ins Co.: _____ Ins ID: _____
Group #: _____ Plan Name: _____
Business Address _____ City _____ State: _____ Zip _____
Phone: (____) _____ Fax: (____) _____ Email: _____
Please present your secondary insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____ Phone: _____
ENT: _____ Phone: _____
SLEEP DOCTOR: _____ Phone: _____
DENTIST: _____ Phone: _____
OTHER MD: _____ Phone: _____
OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _____ Date: _____

