

Registration Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: home: _____ work: _____

Cell Phone: _____ E-mail Address: _____

Social Security Number: _____

Date of Birth: _____ Marital status: _____

Employed by: _____

Medical Insurer: _____

Subscriber #: _____

Subscriber Name if other than patient: _____

Subscriber Date of Birth: _____

Relationship to Subscriber: _____

Secondary Medical Insurer: _____

Subscriber Name if other than patient: _____

Responsible Party: _____

Name of person who referred you to the practice: _____

Sleep Physician's name: _____

Office address: _____

Office telephone: _____

Primary Care Physician: _____

Office address: _____

Date of last exam: _____ Did you have braces? Yes: _____ No: _____

General Dentist: _____

Office address: _____

Date of last exam: _____

Have you had an over night sleep study? Yes: _____ No: _____ If so, when? _____

Do you snore? Yes: _____ No: _____ Don't Know: _____

Have you gained weight in the past year? Yes: _____ No: _____ If so, how much? _____

Have you used CPAP? Yes: _____ No: _____ How long? _____ Pressure level: _____

If any, the reason for stopping: _____

Nightly: _____ 3-6 nights a week: _____ 1-3 nights a week: _____ rarely: _____

Have you had an evaluation with an ear/nose/throat specialist? Yes: _____ No: _____

Have you had any throat or nose surgery? Yes: _____ No: _____

Do you have daytime sleepiness? Yes: _____ No: _____

Is there a family history of snoring? Yes: _____ No: _____

How often do you awaken at night? _____

I hereby authorize payment be made directly to B. Gail Demko, DMD, PC, for services provided to me.

I allow the release of pertinent medical records to my insurance company and my other medical providers.

Signature of Patient: _____ Date: _____

I understand it is my responsibility to obtain referrals **PRIOR to my visit and that co-pays and deductibles are my contractual responsibility and payable at the time of my visit.**

I am also responsible for all fees necessary to collect my bill.

Signature of Patient: _____ Date: _____

All patients must sign the line above or you may not be seen by the doctor.