Saltzer HEALTH
IDAHO SLEEP HEALTH

*****PLEASE READ*****

- Information areas marked with an * are required.
- Photo ID and insurance cards are required at appointment time.
- Copay or Co-insurance payment is expected at appointment time. (Doctor's office only)

PATIENT INFORMATION

*Patient Name:____
*Complete Address:____
*Date of birth:___________________________Marital Status: S M D W
***Social Security #:____**
*Home Phone:_________________________Cell Phone:_____________________________________
*Employer:___________________________*Work phone: ___________________________________
Email address: ________________________________Would you like access to the patient portal? Y or N
Primary Care Provider: ____

Emergency Contact (outside the home):_________________________
Relationship to patient:___________________________________
Emergency contact phone #:_______________________________

How did you hear about us?
Medical provider Friend/family
Online Other

Pharmacy Name:____
Pharmacy Location (cross streets):____

****If patient is a minor, please complete guarantor information below:**

*Guarantor Name:____
*Guarantor Address (if different from above): ____
*Guarantor date of birth: ____________________*Guarantor Social Security #:____________________

INSURANCE INFORMATION

*Primary Insurance Subscriber #:____
*Subscriber Name:________________________________Subscriber Date of Birth:__________________
*Secondary Insurance Subscriber #:____
*Subscriber Name:________________________________Subscriber Date of Birth:__________________

By signing below, you are certifying that all information is true and accurate to the best of your knowledge.

Patient/Guarantor Signature:____Date:__________________
Relationship to patient:____