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: Ⓢ Ⓜ Ⓓ Ⓦ
***Social Security #:**_____
*Home Phone:_____Cell Phone:_____
*Employer:_____*Work phone: _____
Email address: _____Would you like access to the patient portal? Ⓨ or Ⓝ
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:_____