New Patient Forms

Advanced Sleep Conway 1515 9th Avenue, Conway, SC 29526

Basic Information

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth ___/___/___

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License # _____

Demographics

Sexual Orientation _____

Gender Identity _____

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity _____

Race _____

Language _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ **Home** ◯ **Mobile** ◯ **Work** **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** ____ / ____ / ____

Policy ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company **Policy Number**

Insurance Plan **Insurance Phone Number**

Group Number

Insurance Company Address **Address Line 2**

City **State** **Zip**

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following:

Full Name
First Middle Last

Sex ○ Male ○ Female ○ Unknown **Date of Birth** / /

Insurance ID Number **Social Security Number**

Policy Holder Address **Address Line 2**

City **State** **Zip**

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us?