

# LONESTAR

## SLEEP DIAGNOSTICS

### REGISTRATION FORM

(Please Print)

#### Patient Data Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_

Known drug allergies: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Complaints and symptoms: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

#### Insurance Release Information

I hereby authorize my insurance carrier to pay directly to *Healthline Diagnostics* benefits due to me as provided in my contract for services rendered. I understand that I am personally responsible for charges at the in-network benefits rate for my insurance plan, including in-network co-pays and/or deductibles. Additionally, I authorize the release of any medical information necessary to process this claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date: \_\_\_\_\_