



# Progressive Sleep & Wellness - New Patient Form

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## Patient Information

Mr./Ms./Mrs./Dr. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
The best time to contact me is:  Morning  Mid-Day  Evening on  Home phone  Cell phone  Work phone  
Email Address \_\_\_\_\_ Would you like to receive our e-newsletter?  Yes  No  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F Social Security Number (SSN): \_\_\_\_\_  
Height: Feet \_\_\_\_ Inches \_\_\_\_ Weight (lbs): \_\_\_\_ Marital Status:  Married  Single  Life Partner  Minor  
Spouse or Parent/Guardian (if minor) Name: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_

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## Employer Information

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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## Health Insurance Information

Patient's Relationship to Primary Insured:  Self  Spouse  Child  Other  
Name of Insured (First, MI, Last): \_\_\_\_\_ Insured DOB (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_  
Ins Co.: \_\_\_\_\_ Ins ID: \_\_\_\_\_  
Group #: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
*Please present your insurance card so we can photocopy it.*

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## Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE?  YES  NO IF **YES**, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured:  Self  Spouse  Child  Other  
Name of Insured (First, MI, Last): \_\_\_\_\_ Insured DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Ins Co.: \_\_\_\_\_ Ins ID: \_\_\_\_\_  
Group #: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
*Please present your secondary insurance card so we can photocopy it.*

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## Medical Contacts

*Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.*

PRIMARY CARE DOCTOR: \_\_\_\_\_ Phone: \_\_\_\_\_  
ENT: \_\_\_\_\_ Phone: \_\_\_\_\_  
SLEEP DOCTOR: \_\_\_\_\_ Phone: \_\_\_\_\_  
DENTIST: \_\_\_\_\_ Phone: \_\_\_\_\_  
OTHER MD: \_\_\_\_\_ Phone: \_\_\_\_\_  
OTHER MD: \_\_\_\_\_ Phone: \_\_\_\_\_

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I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: \_\_\_\_\_ Date: \_\_\_\_\_