ACCREDITED
MEMBER CENTER

Sleep Disorders Center
OF PRESCOTT VALLEY, LLC

Robert S. Rosenberg, D.O., F.C.C.P.
Board Certified Pulmonary and Sleep Medicine
Medical Director

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: Last _____ First _____ Middle Initial _____

Social Security #: _____ Date of Birth: _____ Age: _____ Gender: ____ Marital Status: (S,M,W,D) _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Email: _____ Pharmacy Name: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ ID #: _____ Group #: _____

Relationship to Patient: _____

Secondary Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ ID #: _____ Group #: _____

Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Guarantor's Name: Last _____ First _____ Middle Initial _____

Social Security #: _____ Date of Birth: _____ Age: _____ Gender: ____ Marital Status: (S,M,W,D) _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Email: _____

I, the undersigned, certify that my dependent or I have insurance coverage as indicated above. I assign directly to Valley Sleep Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Patient/Parent or Legal Guardian Signature **Relationship** **Date**

Please print and bring to your appointment if you have completed this form from our website.

3259 N. Windsong Dr. ♦ Prescott Valley, Arizona 86314 ♦ 928-772-6422 ♦ Fax 928-772-6425