Sleep Disorders Center
OF PRESCOTT VALLEY, LLC

ACCREDITED MEMBER CENTER

3259 N. Windsong Dr.
Prescott Valley, Arizona
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PVsleep.com

RETURNING PEDIATRIC PATIENT UPDATES

PATIENT INFORMATION

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

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____

Pharmacy Name and Phone: _____

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

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: _____

Email: _____ Employer: _____

I, the undersigned, certify that my dependent or I have insurance coverage as indicated above. I assign directly to Sleep Disorders Center of Prescott Valley, LLC 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 or email.
mailto:info@pvsleep.com