COMPREHENSIVE SLEEP CENTER, PC
D/B/A Comprehensive Sleep and Breathing Disorders Center

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Board Certified in Pulmonary & Sleep Medicine by the American Board of Internal Medicine
Board Certified in Sleep Medicine by the American Board of Sleep Medicine

Jeanne Lipscomb, M.D., FCCP
Board Certified in Pulmonary Medicine by the American Board of Internal Medicine

DATE: _____

PATIENT INFORMATION:

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INIT:** ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (Home) _____ (Cell) _____ (Work) _____

OK to leave message? _____ Yes _____ No Sex: M / F Race: _____ Ethnicity: Non-Hispanic Hispanic Refused to report

Marital Status: _____ Birthdate: ___/___/____ Full-time Student: Y / N Part-time Student: Y / N

Retired: Y / N Employed: Y / N Employer: _____ Phone No.: _____

Social Security No: _____ --_____--_____ Driver's License #: _____

Person/Relationship responsible for account: _____ **Relationship to Patient:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (Home) _____ (Cell) _____ (Work) _____

Spouse's Name: _____ Spouse Birthday: ___/___/____Employer: _____

INSURANCE POLICY INFORMATION:

Insurance company (primary): _____

Contract Number: _____ Group # _____

Name of policy holder: _____ Birthdate of policy holder: ____/____/_____

Relationship of patient to policy holder: _____

Insurance company (primary): _____

Contract Number: _____ Group # _____

Name of policy holder: _____ Birthdate of policy holder: ____/____/_____

Relationship of patient to policy holder: _____

REFERRED BY: _____ **PRIMARY CARE PHYSICIAN:** _____

Pharmacy Name: _____ Pharmacy Phone : _____