Chest and Critical Care Consultants

PLEASE FILL OUT FORM COMPLETELY. WE WILL ALSO NEED COPIES OF ANY INSURANCE CARDS.

HEIGHT _____ WEIGHT_____

PATIENT'S NAME FIRST MIDDLE INITIAL LAST

PATIENT'S ADDRESS CITY STATE ZIP

TELEPHONE: HOME: ( ) _____ WORK: ( )_____ CELL: ( ) _____

SOCIAL SECURITY #: _____ AGE: _____ DATE OF BIRTH _____ MARITAL STATUS: S M W D SEP

RACE/ETHNICITY: _____

HAVE YOU BEEN HERE BEFORE? Y or N FAMILY REFERRING PHYSICIAN: _____

PATIENT'S EMPLOYER NAME OCCUPATION

PATIENT'S EMPLOYER ADDRESS: STREET, CITY, STATE, ZIP CODE TELEPHONE ( ) _____

LENGTH OF EMPLOYMENT _____ DO YOU WORK: FULL or PART TIME

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NOTIFY IN CASE OF EMERGENCY: _____ TELEPHONE ( ) _____

RELATIONSHIP TO PATIENT: _____

NEAREST RELATIVE NOT LIVING WITH YOU:_____ TELEPHONE ( ) _____

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AUTHORIZATION TO RELEASE FOLLOW-UP AND/OR CARE NOTES INFORMATION

I. PATIENT NAME: _____ BIRTHDATE: _____

II. I HEREBY AUTHORIZE_____

Name of doctor, hospital or other agency

_____

Street City State Zip

TO RELEASE FOLLOW-UP AND/OR CARE NOTES INFORMATION FOR THE PATIENT IDENTIFIED ABOVE TO SOUTHERN CALIFORNIA SLEEP DISORDERS SPECIALISTS AT CHEST AND CRITICAL CARE CONSULTANTS.

WE ARE ESPECIALLY INTERESTED IN INFORMATION REGARDING CONTINUUM OF CARE FOR ABOVE PATIENT AFTER THEIR STUDY AT THE SLEEP DISORDERS CENTER.

_____ _____ _____

Date Signature of Patient Signature of Parent/or Legal Guardian if Patient is under age 21