Athena Medical Clinic and Sleep Medicine Associates

Patient Information

Name: _____ Date of Birth: ___/___/_____ SS #: ___/___/____
Address: _____ City: _____ State: _____ Zip: _____
Primary #: _____-_____-_____ Secondary #: _____-_____-_____
Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Race: ❑ American Indian ❑ Asian ❑ Black ❑ White ❑ Hispanic ❑ Other _____
Ethnicity: ❑ Hispanic ❑ Not Hispanic Language: ❑ English ❑ Spanish ❑ Other _____
E-mail: _____
Emergency Contact Name: _____ Phone #: _____-_____-_____
Relationship: _____
Referred By: _____ Phone: _____
Pharmacy: _____ Phone: _____

Employment Information	
Employer's Name:	Spouse's Employer:
Employer's Phone:	Employer's Phone:
Job Title:	Job Title:

Spouse / Guardian Information

Name: _____ Date of Birth: ___/___/_____ SS #: ___/___/____

Insurance Information	
Primary:	Secondary:
Phone:	Phone:
Policy #:	Policy #:
Group #:	Group #:
Policyholder:	Policyholder:

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plan to Athena Medical Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Athena Medical Clinic to release all information necessary to secure payment. This release is limited to Office Notes and other procedures that are done at Athena Medical Clinic; it does not include records from hospitals or other physicians. Companies or individuals who are in need of those records should contact that facility. I further authorize the release of these records when they include information concerning drug/alcohol abuse, venereal disease and other statutorily protected diseases, psychiatric records, or AIDS/HIV treatment records. I have reviewed the above information, completed on my behalf, and confirm the accuracy.

Patient's Signature: _____ Date: ___/___/_____
(Parent or Guardian if patient under 18)