Oral Appliance Therapy New Patient Registration

Patient Information:

First Name: _____ Last Name: _____

Middle Initial: _____ Birth Date: _____ Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Phone: _____ ☐ Home ☐ Cell

Email: _____

Age: _____ Weight: _____ Height: _____ ☐Male ☐Female

Who can we thank for referring you to our office? _____

What is the best way to contact you for appointment reminders? ☐Call ☐Text ☐Email

Primary Medical Insurance Information:

Name of Insurance: _____ Member ID#: _____

Name of Subscriber: _____ ☐Self ☐Spouse ☐Child ☐Other

Subscriber Date of Birth: _____ Subscriber Employer: _____

Group Number: _____ Does Patient Have Secondary Insurance: ☐Yes ☐No

Secondary Medical Insurance Information:

Name of Insurance: _____ Member ID#: _____

Name of Subscriber: _____ ☐Self ☐Spouse ☐Child ☐Other

Subscriber Date of Birth: _____ Subscriber Employer: _____

Group Number: _____

Other Information:

Primary Care Physician Name: _____ Phone: _____

Clinic Name & Location: _____

Sleep Physician Name: _____ Phone: _____

Clinic Name & Location: _____

Current Dentist Name: _____ Phone: _____

Clinic Name & Location: _____

_____

Print Patient Name

_____ Date: _____

Patient Signature

_____ Date: _____

Signature of Responsible Party (if other than the patient)