

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:	_____	<input type="checkbox"/> Home	<input type="checkbox"/> Cell		
Email:	_____						
Age:	_____	Weight:	_____	Height:	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Who can we thank for referring you to our office?	_____						
What is the best way to contact you for appointment reminders?	<input type="checkbox"/> Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email				

Primary Medical Insurance Information:

Name of Insurance:	_____	Member ID#:	_____		
Name of Subscriber:	_____	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Subscriber Date of Birth:	_____	Subscriber Employer:	_____		
Group Number:	_____	Does Patient Have Secondary Insurance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Secondary Medical Insurance Information:

Name of Insurance:	_____	Member ID#:	_____		
Name of Subscriber:	_____	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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

Patient Signature

Date: _____

Signature of Responsible Party (if other than the patient)

Date: _____