1275 NW 128th St Ste 200
Clive, IA 50325
(515) 224-3948 P
(515) 224-2944 F
(515) 224-0469 New Pt Fax

Patient's Legal Name: _____ ☐ M ☐F Age _____ DOB _____

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ SS# _____

e-mail: _____

Referring Physician (first/last name & clinic name): _____

Primary Care Physician (First/last name & clinic): _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

_____

_____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Disabled

Retired From: _____

(Please enter Parent/Guardian employment information is patient is a minor)

Student Status: ☐ Full-Time ☐ Part-Time

Spouse/Significant Other: _____ Work Phone: _____

Spouse's Employer: _____ Occupation: _____

Employer Address _____

_____

Emergency Contact (Not Spouse): _____ Relationship: _____

Address: _____ Phone: _____

Language Spoken: _____

Race

☐ American Indian or Alaska Native	☐ Other Pacific islander
☐ Asian	☐ Refused to report/Unreported
☐ Black or African American	☐ Undefined
☐ More than one race	☐ White

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☐ Native Hawaiian	

Ethnicity:

☐ Hispanic or Latino	☐ Refused to Report/Unreported
☐ Not Hispanic or Latino	☐ Undefined

Preferred Pharmacy: _____ Phone: _____

PRIVACY NOTICE ACKNOWLEDGEMENT OF RECEIPT

I have reviewed or received a copy of DSM Sleep Specialists PLC Privacy Practices Notice.

Signed: _____ Date: _____

This acknowledgement will be retained in the patient chart as a HIPAA record at DSM Sleep Specialists PLC.

Insurance

If patient is not the policy holder, we MUST have the policy holder's Date of Birth and Social Security Number.

Primary Insurance	Secondary Insurance
Ins. Company Name _____	Ins. Company Name _____
Legal Name Policy Holder _____	Legal Name Policy Holder _____
Policy Holder's Social Security # _____	Policy Holder's Social Security # _____
Employer Group Name _____	Employer Group Name _____
Group ID Number _____	Group ID Number _____
Policy Holder's Ins. ID # _____	Policy Holder's Ins. ID # _____
Ins. Company Address _____	Ins. Company Address _____
Effective Date _____	Effective Date _____
How did you obtain this policy? _____ (Employer, private pay, etc.)	How did you obtain this policy? _____ (Employer, private pay, etc.)

Payor Questionnaire

1.. Do you or your spouse work for or are retired from a company that provides you with health insurance?	☐ Y ☐ N
2. Are you entitled to Medicare because of disability or End Stage Renal Disease (ERSD)? If yes, please check one: ☐ Disability ☐ Age ☐ ESRD	☐ Y ☐ N
3. Is this illness or injury the result of an automobile accident or other injury? If yes, please check one: ☐ Auto ☐ Injured at home ☐ Other _____	☐ Y ☐ N
4. Is this illness or injury the result of an accident or illness that occurred at work? Date of injury: _____ Work Comp./Employer Contact: _____ Phone: _____	☐ Y ☐ N
5. Has treatment for this accident or illness been authorized by the Veteran's Administration?	☐ Y ☐ N
6. Are you entitled to any benefits under the Federal Black Lung Program?	☐ Y ☐ N
7. Are you a relative of one of the physicians?	☐ Y ☐ N

I herby authorize the release of necessary medical information to insurance to process my claims. I herby assign to the provider all payments for services rendered. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered

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unless other arrangements have been made. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE AMOUNT OF PATIENT LIABILITY AND/OR SERVICES NOT COVERED BY INSURANCE. CO-INSURANCE AND CO-PAYS ARE DUE AT THE TIME OF SERVICE.

Signature: _____ Date: _____