Everything CPAP

Patient Registration

Fx: 208.323.1615
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www.everythingCPAP.com
950 N Cole Rd | Boise, ID 83704

Last Name:_____ First Name:_____ Middle Init:_____

Name you prefer to be called:_____ Date of Birth:_____ Social Security #:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Daytime Phone:_____ Cell Phone:_____

Email Address:_____ Occupation:_____

*What is your preferred method of communication:_____

Financially Responsible Party Name:_____ Date of Birth:_____
(if different from above)

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Relationship to Patient:_____

Emergency Contact:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Relationship to Patient:_____

Medical Insurance

Primary Medical Insurance Company:_____ ID #:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Group #:_____

Secondary Medical Insurance Company:_____ ID#:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Group #:_____

Tertiary Medical Insurance Company:_____ ID #:_____

Policy Holder Name:_____ Policy Holder DOB:_____ Group #:_____

Please provide us with a name or names of people to whom we may disclose confidential information.

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

_____ _____

Signature of Responsible Party Date