



Barry L. Katchinoff, M.D.

*Diplomate of the American Academy of Neurology
Diplomate of the American Board of Sleep Medicine*

Patient Demographics

Patient's Name: _____ Date of Birth: ____/____/____
Last First MI

Preferred Name: _____ Sex: M F Soc. Sec. #: _____

Marital Status: Married Single Life Partner Divorced Separated Widowed

Home Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Emergency Contact: _____ DOB: ____/____/____ Phone: (____) _____

Relationship to patient: _____

Referring Physician: _____ Primary Care Physician: _____

Employer (if applicable): _____ Occupation: _____

Name of Pharmacy: _____ Phone #: (____) _____

In order to keep patient information current, we will ask that you update your patient information every six months to a year and/or when your insurance information or address has changed.

Insurance Information

Primary Insurance: _____ Phone #: (____) _____

Policy/Member ID #: _____ Group #: _____

Name of Policy Holder: _____ Relationship: _____

Place of Employment: _____ Date of Birth: ____/____/____

Secondary Insurance: _____ Phone #: (____) _____

Policy/Member ID #: _____ Group #: _____

Name of Policy Holder: _____ Relationship: _____

Place of Employment: _____ Date of Birth: ____/____/____

Authorization for Release of Information & Authorization to Pay Provider

I hereby authorize the release of patient and medical information to my referring physician, insurance company and hospitals where treatment is rendered that may be pertinent to my care. Such information shall not be released without my signed medical release unless release is required by law. I authorize direct payment from my insurance company to Sleep Diagnostics, LLC and any unpaid balance will be paid by me. In the event that it becomes necessary to refer your account to collections, I agree to pay collection fees in the amount of 33.3% of balance due at the time the account is turned over to an attorney for collection action. Late charges and interest of 1.5% of balances over 60 days may also apply.

Patient's Signature/Guardian: _____ Date: _____