The Houston Sleep Center / Sleep Resources of Houston
Todd J. Swick, MD, PA
Patient Information Sheet

Referring Physician:_____ Address:_____

Physician phone:_____ Fax:_____

Patient Last Name:_____ First:_____ Middle Initial:_____

SSN #:_____ DOB: _____Age:_____ Male/ Female (Status: M/ S/ D)

Telephone #: H :_____W: _____ Cell :_____

Home Address:_____ City, ST. Zip:_____

Your Employer:_____Occupation:_____

Employer Address:_____ City, ST. Zip:_____

Spouse Last Name:_____ First:_____ Middle Initial:_____

SSN#: _____ DOB:_____ Age:_____

Telephone #: H: _____W: _____ Cell: _____

Spouse's Employer:_____ Occupation: _____

Employer Address:_____ City, ST. Zip: _____

Emergency Contact Name:_____ Relationship: _____

Telephone #: H :_____W :_____Cell :_____

Insurance Information: PPO / HMO / POS / EPO / Medicare / Medicaid / Other:_____

Primary Insurance Co.:_____ Insured Name:_____

Telephone #: _____ ID#:_____ Group#:_____

Secondary Insurance Company: _____Insured Name:_____

Telephone #: _____ ID#: _____Group#:_____

AUTHORIZATION TO PAY BENEFITS AND RELEASE INFORMATION TO FILE INSURANCE

I hereby authorize The Houston Sleep Center, Sleep Resources of Houston and Todd J. Swick, MD. PA, to receive payment of insurance benefits or the procedures performed and for services provided. I also understand that a photocopy of this authorization can be used and will be valid as my original signature. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize The Houston Sleep Center, Sleep Resources of Houston and Todd J. Swick, MD., PA , to release any information to the insurance and or referring physician acquired in the course of my examination or treatment.

_____ _____

Signature (Patient / Responsible Party) Date