Florida Sleep Specialists

Diagnosis and Treatment of Sleep Disorders
American Academy of Sleep Medicine Accredited

Jeremy D. McConnell, MD, FOMA

Diplomate, American Board of Family Medicine
Diplomate, American Board of Obesity Medicine
Certificate of Added Qualifications- Sleep Medicine
Fellow, Obesity Medicine Association

Rebecca Martin, ARNP
Rachel Smith, ARNP
Candace Johnson, ARNP

Patient Information Form

Last Name: _____ **First Name:** _____ **MI:** _____

Status: ☐ **S** ☐ **M** ☐ **W** ☐ **D**

Address:_____

Home Phone:_____ **Cell Phone:**_____

Work:_____

DOB:_____ **Age:**_____ **SEX:**___ **Social Security #:**_____

Email Address:_____

Ethnicity: ☐ **Hispanic or Latino**☐ **Non-Hispanic or Latino** ☐ **Other** ☐ **Decline**

Race: ☐**American Indian or Alaska Native** ☐**Asian** ☐**Black or African American**
☐**Native Islander or another Pacific Native** ☐**White** ☐**Other**

Out Of Sate Address_____
City ,State ,Zip:_____ **Home Phone:**_____

Emergency Contact name: _____ **Phone Number:** _____
Relationship to the Patient: _____

PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARDS / PHOTO ID TO COPY FOR YOUR FILE

Referring Physician: _____ **Primary Physician**_____
Primary Insurance: _____ **Policy #:** _____
Insured's Name: _____ **Relationship to Patient:** _____
Secondary Insurance: _____ **Policy #:** _____

ASSIGNMENT OF BENEFITS: *(Allows us to file for your insurance) I hereby assign all medical, to include major medical benefits which I am entitled including Medicare and private insurance and any other health plans to: Sleep Manatee. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as the original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize Sleep Manatee to download my medication history and RX benefits into my account from an RX clearinghouse.*

Signed: _____ **Date:**_____