BEL-RED SLEEP
DIAGNOSTIC CENTER
1414 116th Ave NE Suite F Bellevue, WA 98004
Phone: (425) 451-8417 Fax: (425) 455-4089

PATIENT REGISTRATION

Last Name: _____ First Name:_____ Middle Initial:_____
Birth Date: _____ SSN#:_____ Female☐ Male☐
Home Phone:_____ Mobile Phone:_____
Address:_____ City:_____ State: _____Zip:_____
Occupation:_____ Employer:_____
Employer Address: _____City:_____ State: _____Zip:_____
Work Phone:_____ Person Responsible for this account: _____

INSURANCE INFORMATION

Primary Insurance: _____
Subscriber Name: _____
Subscribe Birth Date: _____
Subscriber SSN#: _____
Insurance Phone #: _____
Policy ID #:_____
Group #: _____
Relationship to Subscriber: _____

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Subscriber Name: _____
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Subscriber SSN#: _____
Insurance Phone #: _____
Policy ID #: _____
Group #: _____
Relationship to Subscriber: _____

REFERRAL INFORMATION

Primary Physician: _____
Phone #: _____

Referring Physician: _____
Phone #: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____Relationship: _____Phone: _____
Address: _____City: _____State: _____ Zip: _____

We will be more than happy to submit a claim to your primary carrier(s), who will return payment and/or explanation of your benefits to our office. If there is any balance owing on your account, our office will notify you. Patients are responsible for all services which are not covered under their insurance plan. Patients are also responsible for obtaining referrals from there PCP if required by their insurance provider; if referral is not obtained before the scheduled clinic visit date, the patient may be responsible for all charges not covered by their insurance company.

I hereby authorize and release my Medicare/insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance provider to release information required for this claim.

I have read and understand the above _____Date:_____