ODOM
DENTAL SLEEP MEDICINE
Snoring | Sleep Apnea | Sleep Bruxism | CPAP Intolerance

5. Patient Information Form

Today's Date: _____ Referred by: _____

Patient Name: First _____ MI: _____ Last: _____ Nick Name: _____

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

Home Phone: _____ Work: _____ Ext: _____ Mobile: _____

Birth Date: _____ Sol Sec # _____ Driver's License # _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

E-mail: _____ I would like to receive correspondence via ☐ E- mail ☐ Mail

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired Occupation: _____

Responsible Party Information

Patient is: ◯ Responsible Party ◯ Primary Insurance Holder ◯ Secondary Insurance Holder

Responsible Party Information if other than patient:

Patient Name: First _____ MI: _____ Last: _____

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

Home Phone: _____ Work: _____ Ext: _____ Mobile: _____

Birth Date: _____ Sol Sec # _____ Driver's License # _____

Primary Medical Insurance Information

Name of Insured: _____ Relationship to patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc Sec # _____ Insured Birth Date: _____

Employer: _____ Ins Company: _____

Address: _____ ID # _____

Address 2: _____ Group # _____

City, State, Zip: _____ Plan Name: _____

Member Service Benefits phone number (back of card): _____

Secondary Medical Insurance Information

Name of Insured: _____ Relationship to patient: ◯Self ◯Spouse ◯Child ◯Other

Insured Soc Sec # _____ Insured Birth Date: _____

Employer: _____ Ins Company: _____

Address: _____ ID # _____

Address 2: _____ Group # _____

City, State, Zip _____ Plan Name: _____

Member Service Benefits phone number (back of card): _____

Health Care Provider Information

Primary Care Physician

Doctor's Name: _____ Specialty: _____

Office Phone: _____ Date of last appointment: _____

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

Other Treating Physician

Doctor's Name: _____ Specialty: _____

Office Phone: _____ Date of last appointment: _____

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

Other Treating Physician

Doctor's Name: _____ Specialty: _____

Office Phone: _____ Date of last appointment: _____

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

Current General Dentist

Doctor's Name:_____ Specialty: _____

Office Phone: _____ Date of last appointment: _____

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

Whom may we thank for referring you? _____