

**Sleep 360 Sleep Diagnostic Center**  
*Complete Solution to your Sleep Problems*  
10601 Pecan Park Blvd. Suite 203, Austin, Texas 78750  
Ph: (512)-810-0360 Fax: (512)-918-0361

**Patient Record Information**

**Please Complete Each Section**

**Patient Information:**

**Patient Name: Last:** ----- **First:** ----- **MI:** ----  
**DOB:** ----- **Marital Status:** ----- **Gender: M / F (circle one)**  
**Address:** -----  
**City:** ----- **State:** ----- **Zip:** -----  
**Home Ph No: (    )----- Cell Ph No: (    )-----**  
**Employer:** ----- **Work Ph No:** -----  
**Address:** -----  
**City:** ----- **State:** ----- **Zip:** -----  
**DL #** ----- **State Issued:** ----- **SSN:**-----

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**Emergency Information:**

**Name:** ----- **Relationship:** -----  
**Address:** -----  
**City:** ----- **State:** ----- **Zip:** -----  
**Home Ph # (    )----- Alternate # (    )-----**

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**Insurance Information: *Avoid if card has been copied***

**Name of the Insurance Company:** -----  
**Policy Holder's Name:** ----- **SSN:**-----  
**Policy/ID #** ----- **Group #** -----  
**Address:** ----- **City/State:** ----- **Zip:**-----

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**Guarantor Information:**

**Name:** ----- **Relationship:** -----  
**SSN:** ----- **DL #** ----- **State Issued:** -----  
**Address:** -----  
**City:** ----- **State:** ----- **Zip:** -----  
**Home Ph # (    )----- Cell Ph # (    )-----**  
**Employer:** ----- **Occupation:** -----  
**Address:** ----- **City/ State:** -----  
**Zip:** ----- **Work Ph # (    )-----**

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I authorize Sleep 360 Sleep Diagnostic Center physicians and / or Physician Assistant to furnish my information to insurance company in order to process my claim. I grant permission to release my medical records if necessary. I understand that I am responsible for my expenses, unless an assignment is accepted and my insurance coverage is contract between the insurance company and myself. I understand that payment is expected at the time of service, unless prior arrangements have been made. I do agree for my insurance money to go to Sleep 360 Sleep Diagnostic Center Physicians and / or Physician Assistants, unless I have paid my balance in full at the time of service.  
Sleep 360 Sleep Diagnostic Center is not responsible for expense of the sleep study.

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**Signature of patient / Guarantor**

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**Date**