TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

Pulmonary and Critical Care Specialists

SLEEP CONSULTANTS, INC.

2941 Oak Park Circle, Suite 200, Fort Worth, TX 76109
Phone (817) 332-7433 Fax (817) 394-6282
Information@SleepConsultants.com
http://www.SleepConsultants.com

Comprehensive Care of Sleep Disorders: Diagnosis, Treatment, Follow-up, Education, Research

PATIENT SELF-REFERRAL

Date: ______________________

Have you had prior sleep testing? – YES / NO If yes, when and where: ______________________

Sleep-related diagnosis(es): ______________________

How did you hear about us? ______________________

Patient Information:

Last Name: ______________________ First Name/Middle Initial: ______________________

Address: ______________________ City/State/Zip: ______________________

Sex: M F Marital Status: M S D W

Email: ______________________ SS#: ______________________ DOB: ______________________

Place a check next to the best phone number to call, so we can contact you to make your appointment.

☐ Home Phone: ______________________ ☐ Work Phone: ______________________

☐ Cell Phone: ______________________ ☐ Other Phone: ______________________

Best time to call: ______________________

Employer: ______________________

Primary Care Physician: ______________________

PCP Phone: ______________________ PCP Fax: ______________________

Other physicians involved in your health care: ______________________

____

Primary Insurance Policy:

Insurance Co. ______ ID No. ______ Group No. ______

Name of Insured ______ Relationship to patient ______

Insured's Birth Date ______ SSN ______ Sex: M F

Claims Mailing Address ______________________

______________________ Phone No. ______

Secondary Insurance Policy:

Insurance Co. ______ ID No. ______ Group No. ______

Name of Insured ______ Relationship to patient ______

Insured's Birth Date ______ SSN ______ Sex: M F

Claims Mailing Address ______________________

______________________ Phone No. ______