Athena Medical Clinic and Sleep Medicine Associates

Patient Information (Please complete ALL sections of this form)

Name: _____ Date of Birth: __/__/__ SS# _____

Address: _____ City: _____ State: ___ Zip: _____

Primary Phone #: _____-_____-_____ Secondary Phone #: _____-_____-_____

Sex: q Male q Female Marital Status: q Single q Married q Divorced q Widowed

Race: q American Indian q Asian q Black q White q Hispanic q Other _____

Ethnicity: q Hispanic q Not Hispanic Language: q English q Spanish q Other _____

E-mail: _____

Emergency Contact Name: _____ Phone #: _____-_____-_____

Relationship: _____

Referred By: _____ Phone: _____

Pharmacy: _____ Phone: _____

Employment Information	
Employer's Name:	Spouse's Employer:
Employer's Phone:	Employer's Phone:
Job Title:	Job Title:

Spouse / Guardian Information

Name: _____ Date of Birth: ___/___/_____

Release of Information

I give permission for Athena Medical Clinic and Sleep Medicine Associates to discuss my medical issues with the following individuals:

Name:	Name:
Relationship:	Relationship:
Phone:	Phone:
Date of Birth:	Date of Birth:

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plan to Athena Medical Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Athena Medical Clinic to release all information necessary to secure payment. This release is limited to Office Notes and other procedures that are done at Athena Medical Clinic; it does not include records from hospitals or other physicians. Companies or individuals who are in need of those records should contact that facility. I further authorize the release of these records when they include information concerning drug/alcohol abuse, venereal disease and other statutorily protected diseases, psychiatric records, or AIDS/HIV treatment records. I have reviewed the above information, completed on my behalf, and confirm the accuracy.

I, _____ (patient's printed name or representative), acknowledge all the above to be true and accurate to the best of my ability.

Patient's Signature: _____ Date: ___/___/_____

(Parent or Guardian signature if patient under 18)