130 Preston Executive Drive Cary, NC 27513 Ph(919)462-8081 Fax(919)462-8082 www.parkwaysleep.com

**Patient Registration Form**

**Please complete using DARK BLACK INK only.**

Name _____ Sex □ Male □ Female

Address _____ City _____ State _____ Zip _____

Date of birth _____ Social Security # _____ Marital Status _____

Home # _____ Cell # _____ E-mail_____

Race_____Ethnicity_____ Language_____

Emergency Contact/Phone # _____Relationship _____

*How did you hear about us?* ☐ Received Mailer ☐ Internet Search ☐ My Doctor ☐ Friend/Family/Colleague

☐ Health Fair ☐ Other_____

**Employment**

Employer _____ Address _____Phone_____

**Insurance Information**

Primary Insurance _____

ID# _____ Group# _____

Customer Service Number _____ Guarantor _____

Secondary Insurance _____

ID# _____ Group# _____

Customer Service Number _____ Guarantor _____

Referring Physician _____ Phone/Fax Number _____

Primary Physician _____ Phone/Fax Number _____

**The following person(s) may access my health account at Parkway (initial as appropriate):**

| | **Financial** | **Supply Pick up** | **Medical Info/Decisions** |
|---|---|---|---|
| Name/Relationship_____ | _____ | _____ | _____ |
| Name/Relationship_____ | _____ | _____ | _____ |

I understand that I am responsible for any services not covered by my insurance company. I authorize payment of any benefits due from my insurance company to Capital Partnership, LLC dba Parkway Sleep Center for services rendered to myself and/or my dependents.

I understand that any and all cost estimates provided to me for any date of service at Capital Partnership, LLC dba Parkway Sleep Center are ESTIMATES ONLY and ARE NOT A GUARANTEE OF BENEFITS. I understand that I am financially responsible for amounts due that differ from any estimate given once the claim has been processed by my insurance company.

**Patient Signature (Parent/Guardian if patient is a minor)** _____ **Date** _____