****REQUIRED: USE FOR EVERY NEW PATIENT AS COVER PAGE.**

PATIENT INFO SHEET

CLEAR FORM

Patient Information

Full Name _____ Date of Birth _____

Address _____

Phone No. _____ SS No. _____

Mark applicable:

☐ Male	☐ Married	☐ Student	**OR**	☐ Not Employed
☐ Female	☐ Single	☐ Employed		☐ Retired

Medical Insurance

Insurance Name _____

Subscriber Number _____

Group Number _____

Provider/Customer Service Phone No. _____

YOUR DENTIST'S NAME ON ACCOUNT WITH US: Tammy Sue Rhea-Bohnenkamp DDS	EMAIL THIS REPORT TO: info@SiouxlandSleepSolutions.com
YOUR DENTAL OFFICE'S NAME: Siouxland Sleep Solutions	ADDITIONAL NOTES:

Copy of Medical Insurance Card Attached, if possible, enlarge to 150%.
(Front & Back – If you cannot read the card, we will not be able to either)

Please fax back after each appointment to 209-682-5535
Questions or Need Help? Please call 209-527-1995