WOMENZZZ SLEEP HEALTH, P.L.L.C.
Laura L'Heureux, D.O.

Patient Information

Patient Name: _____ Date: _____
Last First M.I.

Birth Date: _____ Sex: ___M ___F Age:_____

Marital Status: ___M ___D___W ___S ___other Social Security#_____

Home Address: _____
Street apt/lot# City State Zip

May we leave a message regarding test results at any of the following?

Phone: Home_____yes___ no___ Cell_____yes___no___

Work_____yes___no___ Email_____yes___no___

Emergency Contact:_____
name relationship phone#

Occupation:_____ Employer:_____
Name

_____
Address Phone

Primary Insurance: _____
Name Phone#

_____
Group# ID#

Primary Insured/Policy Holder: _____
(if different from patient) Name social security#

Secondary Insurance: _____
Name Phone#

_____
Group# ID#

Pharmacy: _____
Name Address Phone

Primary Care Physician:_____Phone:_____

How did you learn about us? Physician___ Friend___ Internet___ Our Web Site___
Other_____

By providing the above information I authorize Laura L'Heureux, D.O., her employees, or her appointed agents to contact me regarding my care. I hereby authorize Laura L'Heureux, D.O., or her appointed agents to furnish information to insurance carriers, or other 3rd party payers concerning my illness and treatment to include review activities related to my physician's participation with my health plan. I further authorize my insurance carrier to pay directly to Laura L'Heureux, D.O. all medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. I understand that it is my responsibility to pay in a current manner any balance of said professional service charges over and above this insurance payment. A photocopy of this authorization shall be as effective and valid as the original.

Signature:_____ Date:_____