
The Center for Respiratory and Sleep Disorders

44000 West 12 Mile Road, Suite 113, Novi, MI 48377 **248.465.9253 (WAKE)**

Physician

Referring Physician

Reason for Consultation

Date Scheduled

Authorization to Send Note to Your Referring Physician

YES

NO

(Please X the appropriate box)

Other Physicians Involved in Your Care

Patient Name

Sex

Social Security Number

Date of Birth

Home Address

Home Phone

Cell Phone

Business Phone

Spouse Name

Phone

Employer Name

Phone

Emergency Contact Name

Phone

Referring Physician Name

Phone

Address

Primary Insurance Company

Insured's Name

Contract #

Date of Birth

Social Security Number

Relationship of Patient

Effective Date

Secondary Insurance Company

Insured's Name

Contract #

Date of Birth

Social Security Number

Relationship of Patient

Effective Date

I hereby authorize Haapaniemi-Lesser Associates to release any medical information necessary for treatment or for insurance claims pertaining to payments. I understand that I am financially responsible to the above parties for the balance of any payment not covered by my insurance company. I understand that I am responsible for obtaining referrals related to procedures and office visits.

I authorize the above parties to release medical information as needed to other physicians, hospitals, and health care entities to facilitate my treatment.

Signature of Patient

Date
