2741 Debarr Rd. Ste C302 Anchorage, AK 99508
Tel: 907.331.3612
Fax: 206.374.8248

PATIENT INFORMATION

Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: _____

SSN: _____

Mailing Address: _____ Unit/Apt #: _____

City: _____ State: _____ Zip Code _____-_____

Phone: _____ Type of number: Home / Mobile / Work **(Primary Contact Phone).**

Email: _____

Emergency Contact Information:

First Name: _____ Last Name: _____

Mailing Address: _____ Unit/Apt #: _____

City: _____ State: _____ Zip Code _____-_____

Phone Number: _____

Relationship: _____ **(Are we able to share medical information with this person?)** [Yes / No]

How did you hear about Peak Medical Equipment? _____

Date of original Sleep Study: _____

Facility Sleep Study was performed: _____

Phone number of facility: _____

Are you currently being treated for Obstructive Sleep Apnea? _____

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INSURANCE INFORMATION

Primary Insurance Coverage: _____

Claims Mailing Address: _____

Insurance Company Phone: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder Date of Birth: _____

Policy Holder's SSN#: _____ Relationship to Patient: _____

Secondary Insurance Coverage: _____

Claims Mailing Address: _____

Insurance Company Phone: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder Date of Birth: _____

Policy Holder's SSN#: _____ Relationship to Patient: _____

Tertiary Insurance Coverage: _____

Claims Mailing Address: _____

Insurance Company Phone: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder Date of Birth: _____

Policy Holder's SSN#: _____ Relationship to Patient: _____

AUTHORIZATION: I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government health benefits either to myself or to my physician who accepts assignment. I authorize payment of medical benefits to Peak Medical Equipment, LLC for services provided. I understand that I am financially responsible for all charges whether paid or not by my insurance company.

Patient (or Authorized) Signature: _____ **Date:** _____