CENTRAL VA SLEEP CENTER
AASM ACCREDITED FACILITY
VIKAS GUPTA, M.D. D,ABSM
912 LAFAYETTE BLVD., FREDERICKSBURG, VA 22401
540-656-2811 • FAX 540-479-6961

Patient's Last Name _____ First Name _____ MI _____

Address _____

City _____ State Code _____ Zip Code _____

Referring Dr _____

Phone # _____ Sex (M / F) _____ Marital Status _____ S M D W

Birthday _____ / _____ / _____ SSN _____ / _____ / _____

Home Phone (_____) _____ Work Phone (_____) _____

Emergency _____ Emer Phone (_____) _____

E-mail _____ Cell Phone (_____) _____

Language _____ Race _____ Ethnicity _____

Primary Insurance Coverage

Company _____

Insured Name _____

Relationship _____ DOB _____

Co-pay Amount _____

Policy Number _____

Group Number _____

Employer _____

Secondary Insurance Coverage

Company _____

Insured Name _____

Relationship _____ DOB _____

Co-pay Amount _____

Policy Number _____

Group Number _____

Employer _____

Guarantor Information

Guarantor _____

Address _____

City _____ State Code _____ Zipcode _____

Telephone (_____) _____ Miscellaneous _____

Patient's Authorization

I authorize CENTRAL VA SLEEP CENTER to apply for benefits on my behalf for services rendered by CENTRAL VA SLEEP CENTER. I request payment from my insurance company be made directly to CENTRAL VA SLEEP CENTER. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____ _____

Signature of Subscriber or Beneficiary Date