FAUQUIER HEALTH
Sleep Center

Sleep Lab Patient Demographic Form

Please complete this form to help us provide you with the best care. All information is confidential.

Personal Information

- **Full Name:** (First)_____ (Last) _____
- **Date of Birth (MM/DD/YYYY):** _____
- **Gender:** ☐ Male ☐ Female ☐ Other: _____ Preferred **Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Contact Information

- **Address:** _____
- **City:** _____
- **State:** _____
- **ZIP Code:** _____
- **Phone Number:** _____ ☐ Home ☐ Mobile
- **Email Address:** _____

Emergency Contact

- **Name:** _____
- **Relationship to Patient:** _____
- **Phone Number:** _____
- **Alternate Phone Number:** _____

Insurance Information

- **Primary Insurance Provider:** _____ **SSN:** _____
- **Name of Policy Holder (if different from the patient)** _____ **and, DOB:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Secondary Insurance Provider (if applicable):** _____
- **Policy Number:** _____

Name of Referring Physician: _____ Primary **Care Physician:** _____

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Have you had a previous sleep study? ☐ Yes ☐ No, If yes, where, and when?

_____

_____

Do you use any sleep aids (e.g., CPAP, medication)? ☐ Yes ☐ No

- If yes, specify: _____