Registration Form

2SleepWellAgain.com

Dr. Frank Barbieri ☐
HILTON HEAD / BLUFFTON

Dr. Alan Barbieri ☐
GREATER CHARLESTON

Date:_____ Male: _____ Female: _____ Date of Birth:_____

Name: _____ Social Security # _____
For your security, fill in after you arrive at the office

Address: _____ Home Phone: _____
House # Street Apt#

_____ Cell Phone: _____
City State ZIP

Email: _____ Driver's License #: _____

❑ Retired ❑ Employed by: _____

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Insurance Company: _____ Policy#: _____

Name on Policy: _____ Ins. Co. Phone: _____

****

Name of Spouse: _____ Social Security # _____

Date of Birth: _____ Work Phone: _____

Spouse Employed By: _____

****

REFERRED BY:
❑ Newspaper ❑ TV ❑ Internet
❑ Friend ❑ MD/DDS

CONTACT IN CASE OF EMERGENCY

_____ _____
Name Name

_____ _____
Address Relationship

_____ _____
City State Zip Phone

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Chief Complaint: _____

Are there any special conditions we should know about? _____

METHOD OF PAYMENT: CASH_____ CREDIT CARD _____ CHECK_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the cost of my treatment. I have read all of the information on this sheet and have completed the answers. I certify that this information is true and correct to the best of my knowledge.

_____
Signature