RED RIVER SLEEP CENTER

Paul A. Guillory, MD | Renick P. Webb, MD
"Leaders in helping you feel truly rested."
AASM ACCREDITED

PATIENT DEMOGRAPHIC FORM

Date _____

Legal Name _____ Age _____ Date of Birth _____ Race _____
Last First Middle

Marital Status: ☐ single ☐ married ☐ other _____ Employed: ☐ Yes | ☐ No Smoker in household: ☐ Yes | ☐ No

Sex: ☐ M ☐ FM ☐ OTHER Social Security # _____ Drivers License # /State _____

Mailing Address _____ APT# _____

City / State / Zip _____Email_____

Phone: Home # _____ Work # _____ Cell # _____ Fax # _____

Preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Other _____

Employer _____ Employer's Address _____
PO Box/Street City/State/ZIP

Nearest relative not living with you _____ Phone # _____ Relationship _____

Allergies (list all): _____

Special needs (list all): _____

Primary Doctor _____ Cardiologist _____
CITY / STATE CITY / STATE

Other Doctor (s) _____ _____
(PLEASE INDICATE TYPE OF DOCTOR/SPECIALTY, AND CITY / STATE

Emergency Contact: _____ Relationship: _____

Home # _____ Cell # _____ Address _____

GUARDIAN/PARENT INFORMATION (If patient is under 18) ☐ Spouse ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Name _____ Social Security # _____ DOB _____ Employer _____

Address _____ Phone: work # _____ other # _____

A $100 setup charge is applied for No Show appointments. Please call our office at (318) 443-1684 at least 24 hours in advance if you need to cancel and/or reschedule your sleep testing appointment.

PLEASE FILL OUT & SIGN THE BACK OF THIS FORM