



**Dr. Alexander A. Clerk's Office**  
 O'Connor Health Center 1  
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Sleep Disorders Clinic

Clinic Confidential Patient Information

**Patient Information**

Patient's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (MM/DD/YY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Home Address: \_\_\_\_\_  
City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other (Cell): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_  
City State Zip Code

Email: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Education:  Grade School  High School  College  Postgrad  Graduate School  
 Marital Status:  Minor  Single  Married  Widowed  Separated  Divorced  Cohabiting  
 Ethnicity/Race:  Decline  Caucasian  African American  Asian American  Native American  Hispanic  Other Hispanic

**Insurance Information**

Same as above  
**Primary Insurance:** \_\_\_\_\_  HMO  PPO  Other Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Group #: \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **Subscriber's Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **ID #:** \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Claims Address: \_\_\_\_\_  
City State Zip Code

Same as above  
**Secondary Insurance:** \_\_\_\_\_  HMO  PPO  Other Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Group #: \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **Subscriber's DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **ID #:** \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Claims Address: \_\_\_\_\_  
City State Zip Code

**Guarantor/Responsible Party**

Guarantor's Name: \_\_\_\_\_ Guarantor's Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other (Cell): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Referring Physicians**

Physicians Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
City State Zip Code

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ May we Consult This Doctor?  Yes  No