Jamil S. Sulieman, M.D., Inc.
Pulmonary and Sleep Medicine

THE SLEEP LAB OFFICE
A Sleep-Related Breathing Disorders Laboratory
46-001 Kamehameha Highway, Suite 314
Kaneohe, Hawaii 96744
TELEPHONE: (808) 234-0033
FAX (808) **234-0055**

KAILUA OFFICE
642 Ulukahiki Street, Suite 303
Kailua, HI 96734
TELEPHONE: (808) 234-0033
FAX (808) **234-0055**

NEW PATIENT INFORMATON

Last Name _____ First Name _____ Middle Initial _____ Suffix _____

Date of Birth _____ M / F SSN _____ Marital Status _____

Hispanic □Yes □No Ethnicity _____ OR □ More than one Race Language _____

Mailing Address _____ City/State/Zip _____

Physical Address _____ City/State/Zip _____

Home Number _____ Work _____ Cell _____ May we leave messages? □Yes □No

Email _____ Would you like communications through email? □Yes □No

Employer _____ Position _____ Address _____

INSURANCE

Primary _____ Subscriber # _____ Group # _____ HMO / PPO

Subscriber Name _____ D.O.B. _____ SSN: _____ Relation _____

Secondary _____ Subscriber # _____ Group # _____ HMO / PPO

Subscriber Name _____ D.O.B. _____ SSN: _____ Relation _____

Tertiary _____ Subscriber # _____ Group # _____ HMO / PPO

Subscriber Name _____ D.O.B. _____ SSN: _____ Relation _____

Guarantor Name _____ SSN: _____ D.O.B _____ Relation _____

Emergency Contact _____ Phone _____ Cell _____ Relation _____

Relative not residing with you _____ Phone _____ Cell _____ Relation _____

I certify that the above information that I have provided is true and accurate to the best of my knowledge.

Signature _____ Relation _____ Date _____

Appointment Acknowledgement

Due to the nature of our practice, Dr. Sulieman may be expected to attend to pulmonary emergencies at the hospital. In the event that a medical emergency occurs, your appointment may be delayed or rescheduled. Every effort possible is made to lessen the inconvenience, and we will contact you immediately should a change occur. We appreciate your understanding on this matter. Please provide us with the best possible alternate forms of contact that we may utilize should there be a need to reach you.

I acknowledge and understand that there may be sudden, unforeseen circumstances where my appointment may be delayed or rescheduled, and that I have provided the best possible forms of contact for the office to reach me should the need occur.

Signature _____ Relation _____ Date _____

Correspondence with Hospitals and Emergency Personnel

If in the event you are admitted into the hospital, the attending physicians may ask for medical information and history from Dr. Sulieman to help in your treatment. They may ask for progress notes, test results, imaging reports and other tests or procedures ordered by or in the possession of Dr. Sulieman. By signing below, you allow Dr. Jamil S. Sulieman and staff to send medical records to the hospital and acknowledge that the release of this information is for medical care and treatment, and physician consultation and correspondence.

Signature _____ Relation _____ Date _____