**BOICE SLEEP DISORDERS LABORATORY**
**NAVAL MEDICAL CENTER PORTSMOUTH**
**PORTSMOUTH, VA 23708**

# PATIENT INFORMATION COVER SHEET

## Section 1:

**TODAY'S DATE: _____**

**Name: _____ Sponsor last 4 of SSN: /_____**

**RANKRATE: _____Dependency Status/CODE: _____**
**(Wife, son, daughter, etc.,)**

**Home Address: _____**
**(Street) (City) (State) (Zip)**

**Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____**
**(Home) (Work) (Cell)**

**E-mail Address: _____**

## Section 2: (Personal)

**Gender: M/F Date of Birth: _____/_____/_____ Height: _____ Weight: _____**
**(Circle one) (DAY) (MM) (YEAR)**

**Marital Status: Single / Married / Divorced**
**(Circle one)**

**Insurance: TRICARE/ TRICARE PRIME**
**(Circle one)**
**Do you have any other insurance other than TRICARE PRIME?_____**

## Section 3: ACTIVE DUTY ONLY

**Branch of Service: USN / USA / USAF / USCG / USMC**

**Assigned Command: _____**

**Command Address: _____**
**_____**
**_____**

**Command Phone: (____) _____-_____**

**PRD: _____ EAOS: _____**

**Who is your primary doctor? (On ship, branch clinic, etc.)_____**