



This Patient Registration Form has been provided to you to complete in an effort to help your physician gain an understanding of your sleep medical background and the nature of the current sleep problem(s). **Please complete all the questions as thoroughly as you can.** Please be assured that all your information is held in strict confidence. **THANK YOU** for completing this important questionnaire.

Last Name: _____	First Name _____	Middle Initial _____
Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Maiden Name: _____
Date of Birth: (mo/d/yr): _____/_____/_____	SSN#: _____	
School Grade (if applicable): _____		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		
Home Phone (____) _____	Work Phone: (____) _____	Mobile (____) _____
Email: _____		Driver's License #/State _____
Emergency Contact: Name _____		Phone: (____) _____
Current Height? _____	Weight? _____	Weight 5 years ago _____

Street Address _____
City: _____ **State** _____ **Zip** _____

How did you hear about us? <input type="checkbox"/> Referral by physician <input type="checkbox"/> Internet <input type="checkbox"/> Friend/family <input type="checkbox"/> other
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Referring Doctor: _____ **Group Name:** _____
Office Phone #: _____ **Specialty:** _____
Primary Care Physician _____ **Group Name** _____
Office Phone # _____ **Specialty:** _____

Reason for Referral: _____		
Main Sleep Problem (check all that apply):		
<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Difficulty staying asleep	<input type="checkbox"/> Early morning awakening
<input type="checkbox"/> Snoring	<input type="checkbox"/> Bedpartner requested evaluation	<input type="checkbox"/> Stop breathing in sleep
<input type="checkbox"/> Restless Sleep	<input type="checkbox"/> Being unrefreshed in the morning	<input type="checkbox"/> Daytime sleepiness

Employer Information: Name: _____ Phone: _____

Please describe your sleep

problem(s): _____

1. How often do these symptoms occur? Every night two or more times a week Other
Explain _____
2. How long have you been experiencing these symptoms:
 2+yrs 1-2 yrs several months last few weeks
3. At what age did your sleep problem begin? _____
4. On a scale of 1-10, indicate the severity of your symptoms 1 (mild)- 10 (severe): _____
5. Current state of health: Excellent Good Fair Poor Very poor
6. Is there a family history of a sleep disorder? Yes No
7. Who in the family has a sleep problem Mother Father Sibling
Explain _____
8. What is the family sleep disorder _____

Epworth Sleepiness Scale

How likely are you (or your child) to doze off or fall asleep in the following situations in contrast to just feeling tired". Score a 0 if you would never doze, 1 slight chance of dozing, 2 moderate chance and 3 high chance

- | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|
| Sitting and reading or being read to: | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Sitting inactive in a public place (meeting, church) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| As a passenger in a car for an hour without a break | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Lying down to rest in the afternoon when circumstances permit? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Sitting and talking to someone | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Sitting quietly after lunch without alcohol | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| In a car, while stopped for a few minutes in traffic | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

Total Score: _____

Insurance Information:

Primary Insurance Plan Name _____

Patient's Name: _____ Insurance Phone # _____

Patient's relationship to policy holder: Self Spouse Child Other _____

ID/Certification # _____ Policy Group # _____

Issue Date (M/D/Yr): _____ Exp. Date: _____ CoPay Amt _____

Policy Holder:

Last Name _____ First Name _____ Middle Name _____

Maiden Name: _____ DOB(m/d/yr) _____ Male Female

Employer: _____

Address to send claims: _____

Secondary Insurance Plan Name _____

Patient's Name: _____ Insurance Phone#: _____

Patient's relationship to policy holder: Self Spouse Child Other _____

ID/Certification # _____ Policy Group # _____

Issue Date (M/D/Yr): _____ Exp. Date: _____ CoPay Amt _____

Policy Holder:

Last Name _____ First Name _____ Middle Name _____

Maiden Name: _____ DOB(m/d/yr) _____ Male Female

Employer: _____

Address to send claims: _____

The End! Thank you.