



This Patient Registration Form has been provided to you in an effort to help your physician gain insight into your child's sleep medical background and the nature of his/her 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.

**Child's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:**  Male  Female

**Date of Birth:** (mo/d/yr): \_\_\_\_/\_\_\_\_/\_\_\_\_  Term  Preterm

SSN#: \_\_\_\_\_ School Grade: \_\_\_\_\_

**Parent's Daytime Phone** (\_\_\_\_) \_\_\_\_\_ **Parent's Evening Phone:** (\_\_\_\_) \_\_\_\_\_

**Parent's Cell Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

Current height? \_\_\_\_\_ Weight? \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**How did you hear about us?**  Referral by physician  Internet  Friend/family  other

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):

Difficulty falling asleep  Difficulty staying asleep  Early morning awakening

Snoring  Stop breathing in sleep  Difficulty to awaken in am

Restless Sleep  Being unrefreshed in the morning  Daytime sleepiness

Responsible Party Name \_\_\_\_\_ Occupation \_\_\_\_\_

SS# \_\_\_\_\_ Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Please describe your child's sleep problem(s):

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1. How often do these symptoms occur? Every night two or more times a week Other  
Explain \_\_\_\_\_

2. How long has your child been experiencing these symptoms:

2+yrs  1-2 yrs  several months  last few weeks

3. At what age did your child's 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 (if appropriate-older child/teenager)

**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:  0  1  2  3

Sitting inactive in a public place (school, church)  0  1  2  3

As a passenger in a car for an hour without a break  0  1  2  3

Lying down to rest in the afternoon when able?  0  1  2  3

( Not appropriate if child is still napping)

Sitting and talking to someone  0  1  2  3

Sitting quietly after lunch.  0  1  2  3

In a car, while stopped for a few minutes in traffic  0  1  2  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 I \_\_\_\_\_

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 for filling out this information*