BEL-RED SLEEP
DIAGNOSTIC CENTER
1414 116th Ave NE, Ste F, Bellevue, WA 98004
Phone: 425-451-8417 Fax: 425-455-4089
www.bel-redsleepdiagnosticcenter.com

Patient Registration

Patient's Name (Last, First, MI): _____

Date of Birth: _____ Age: _____ Sex: M / F Social Security Number: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home Number: _____ __ _____ Mobile Number: _____

Patient's Employer: _____ Work Phone: _____

Email: _____

Person To Notify In Case of Emergency

Name: _____Relationship: _____Phone: _____

Insurance Information

Please bring your ID and insurance card

Primary Insurance: _____
Subscriber Name: _____
Subscribe Birth Date: _____
Member ID #:_____
Relationship to Subscriber: _____

Secondary Insurance: _____
Subscriber Name: _____
Subscriber Birth Date:_____
Member ID #: _____
Relationship to Subscriber: _____

Referral information

Primary Physician: _____
Phone #: _____

Referring Physician: _____
Phone #: _____

Name(s) of other health care providers your information should be sent: _____

We are more than happy to submit your claim to your insurances(s), who will return payment and/or explanation of benefits to our office. If there is any balance owing on your account, our office will notify you. Patients are responsible for all services which are not covered under their insurance plan. We urge patients to call their insurance provider before rendering any services to verify coverage. Patients are also responsible for obtaining referrals from their PCP if required by their insurance provider; if the referral is not obtained before the schedule clinic visit date, the patient may be responsible for all charges not covered by their insurance provider.

I hereby authorize and release Medicare/insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance provider to release information for this claim

I have read and understand the above: _____ **Date:** _____

Please indicate the main concerns for which you seek help from our sleep clinic:

◯ Snoring ◯ Sleepiness ◯ Breathing Pauses ◯ Restless Legs ◯ Insomnia ◯ Tiredness ◯ Other

Have you been evaluated in a sleep clinic in the past? Y / N

If "Yes" please complete this section.
If "No" Please go to "your breathing patterns during sleep"

Where and when? _____ Were you diagnosis with obstructive sleep apnea? Y / N

List any other diagnoses_____ Have you been treated with a CPAP machine? Y / N

Are you currently using a CPAP? Y / N If not, why_____

Current CPAP pressure setting?_____ Do you have a current CPAP supplier? Y / N if yes, who?_____

Have you had a surgery for apnea? Y / N Have you ever tried a dental device? Y / N

You're Breathing Patterns During Sleep

How loud is your snoring? ◯ No snoring ◯ Mild ◯ Moderate ◯ Loud ◯ Very Loud

How long have you been told you snore? _____

Has your snoring worsen over time? Y / N

Have you ever awakened choking or gasping sound during sleep? Y / N

Has anyone ever told you that your breathing Pauses during sleep? Y / N

Have your gained or lost weight in the last year? Y / N If yes how much?_____

Your Typical Sleep Schedule

What time do you usually go to bed on: Weekdays_____Weekends_____

What time do you usually awaken? Weekdays_____Weekends_____

How much sleep would you estimate that you get each night? Weekdays_____Weekends_____

How many hours of sleep do you get on weekdays?_____

How many times to you wake up at night on average?_____

Do you usually have trouble falling back to sleep? Y / N

What usually cause your awakening?_____

If you need to use the bathroom, how many times do you usually need to go at night?_____

Have you been feeling tired or sleepy? Y / N

Do you take naps? N / Y If yes, how long?_____ How many days per week do you usually nap?_____

How many times per day?_____ Do you doze off while driving? Y / N

Have you ever taken medications to improve your sleep? Y / N If yes, which medications and were they effective?

_____

_____

How likely are you to doze off or fall asleep (not just feel tired) in the following situations?

Note: This refers to your usual way of life in recent times. If you have not done some of these things recently, try to determine the ways in which might be in these situations.

	No Chance	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (theater, meeting or bus)	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	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
Sitting and talking to someone	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total score_____

How often does each item apply to you? (Check the number applies to you)

	No Chance	Slight Chance	Moderate Chance	High Chance
Restless sleep	0	1	2	3
Wake up with dry mouth	0	1	2	3
Wake up with sore throat	0	1	2	3
Wake up feeling non-restful	0	1	2	3
Difficulty waking up	0	1	2	3
Nasal or Sinus Congestion	0	1	2	3
Heartburn	0	1	2	3
Clenching/Grind teeth while sleeping	0	1	2	3
Nightmares	0	1	2	3
Acting out dreams while sleeping	0	1	2	3
Feeling tired or sleepy	0	1	2	3
Feeling down or sad	0	1	2	3
Difficulty concentrating/focusing	0	1	2	3
Difficulty with memory	0	1	2	3
Irritable most of the day	0	1	2	3
Sleep walking	0	1	2	3
Sleep talking	0	1	2	3
Leg Cramps	0	1	2	3
Restlessness or discomfort of the legs at bedtime	0	1	2	3
Urge to move legs	0	1	2	3
Momentary paralysis when falling asleep	0	1	2	3
Sudden muscle weaken brought on by strong emotion	0	1	2	3

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Past Medical History

Please check all that apply

Heart Attack		Ulcers		Smoking		Arthritis	
Heart Disease		Acid Reflux		Asthma		Low back pain	
Heart Failure		Liver Disease		Emphysema/COPD		Neck Pain	
Irregular Heartbeats		Colitis		Recurrent sinus infection		Knee/hip pain	
High blood pressure		Irritable bowel syndrome		Allergies		Shoulder pain	
High Cholesterol		Diabetes		Nasal Congestion		Fibromyalgia	
Head Injury		Hypothyroidism		Depression		Stroke	
Prostate enlargement		Hyperthyroidism		Anxiety Disorder		Seizure disorder	
Kidney disease		Tonsil/Adenoid remove		Bipolar		Parkinson's disease	
Anemia (any history)		Nasal Surgery		Cancer		Migraine headaches	

Other:_____

Medication

Are you allergic to any medications? Y / N If yes, please list the names of the medications_____

_____

List all medications, including over the counter medications and supplements

Medication	**Dosage**	**Times per day**

Your Family History

Does anyone in your immediate family (parents, sibling or children) have the following medical conditions?
Please Circle

Sleep Apnea	Father	Mother	Sibling	Child
Snoring	Father	Mother	Sibling	Child
Narcolepsy	Father	Mother	Sibling	Child
Restless Leg Syndrome	Father	Mother	Sibling	Child

Your Social History

Marriage status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Domestic Partner

Work Status: ◯ Employed ◯ Retired ◯ Unemployed ◯ Disabled ◯ Student

Occupation:_____ What is your highest level of education completed?_____

How many caffeine-containing beverages do you consume on a typical day?

Coffee_____ Tea_____ Caffeinated soft drink_____ Last drink of the day _____

How often do you drink alcoholic beverages?_____ Do you use illicit street drugs? Y / N If yes, please list_

_____

Tobacco use: ☐ Never ☐ Current smoker ☐ Former smoker Quit date_____

Current weight_____Weight 5 years ago_____ Height_____ If known neck size_____

Feel free to write down any other issues you might have in regards to your sleep.

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out these forms. Please make sure to bring this packet with you to your scheduled appointment. You may also email your new patient packet to info@bel-redsleepdiagnosticcenter.com

CANCELLATION POLICY

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that assists us in scheduling appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient in need of our services.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office by noon the day before, it will be considered a missed appointment unless it is an emergency. A fee of ***$50.00*** will be charged for a missed office appointment.

Additionally, if a patient is more than15 minutes late to his/her appointment, he/she will be seen when possible that same day.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage and understanding.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Bel-Red Sleep Diagnostic Center's Appointment Cancellation Policy.

_____ _____

Printed Name of the Patient Relationship to Patient (if the patient is a minor)

_____ _____

Signature of Patient or Responsible Party if a Minor Date