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

New Patient Demographic

Patient Information

First Name _____ **Last Name** _____ **MI** _____

Date of Birth _____ **Gender** _____ **Language** _____

Address_____
City / State / Zip Code

Email _____

Primary Phone _____ **Is it okay to leave a voicemail? Yes☐No☐**

Emergency Contact

First Name _____ **Last Name** _____

Phone Number _____ **Relationship** _____

Insurance

Insurance Name _____

Member ID # _____ **Group #** _____

Subscriber Name _____

Date of Birth _____ **Relationship** _____

Primary / Referring Physician

Clinic Name _____ **Physician Name** _____

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What is the reason for sleep clinic visit?_____

_____

Check the box if you have following symptoms:

- ☐ Loud snoring
- ☐ Frequent awakenings at night
- ☐ Choking for breath at night or gasping during sleep
- ☐ Witnessed Apnea (I've been told that I stop breathing when asleep)
- ☐ Restless sleep
- ☐ Awaken un-refreshed
- ☐ Crawling feelings in legs when trying to sleep
- ☐ Leg-kicking during sleep
- ☐ Leg cramps in sleep
- ☐ Trouble falling asleep or staying asleep at night
- ☐ Racing thoughts when trying to sleep
- ☐ Fear of being unable to sleep
- ☐ Inability to fall back asleep after awakening at night
- ☐ Laying in bed worrying when trying to sleep
- ☐ Waking too early in the morning
- ☐ Sleep talking
- ☐ Sweating a lot at night
- ☐ Waking up to urinate
- ☐ Teeth grinding during sleep
- ☐ Nightmares
- ☐ Morning headaches
- ☐ Morning dry mouth
- ☐ Sleepwalking
- ☐ Sleep terrors
- ☐ Tongue biting in sleep
- ☐ Acting out dreams
- ☐ Feeling paralyzed when falling asleep or waking up
- ☐ Dreamlike images when falling asleep or waking up
- ☐ Sudden weakness when laughing or afraid
- ☐ Uncontrollable daytime sleep attacks
- ☐ Falling asleep unexpectedly
- ☐ Falling asleep at work or school
- ☐ Falling asleep while driving
- ☐ Recent change in sleep schedule
- ☐ Shift work interfering with sleep
- ☐ Pain interfering with sleep; where is the pain?
- ☐ I use sleeping pills to help me sleep.

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Sleep Schedule:

Week days or work days: Bed Time_____ Wakeup Time_____

Weekends or non-work days: Bed Time_____ Wakeup Time_____

Do you take naps? ☐ Yes ☐ No _____ naps per week

Have you ever had a sleep study in the past: ☐ Yes ☐ No

Sleep lab/ clinic name where you had sleep study_____

Do you currently use CPAP/ BiPAP at home: ☐ Yes ☐ No

CPAP/ BiPAP pressure: _____ Oxygen: ☐ Yes ☐ No _____L/min

Current DME (Durable Medical Equipment) company:_____

Epworth Sleepiness Scale Scoring:

How likely are you to doze off or fall asleep in the following situations. Please circle the appropriate number in each line.

Never	Rarely	Frequent	Always	
☐ 0	☐ 1	☐ 2	☐ 3	Sitting and reading
☐ 0	☐ 1	☐ 2	☐ 3	Watching TV
☐ 0	☐ 1	☐ 2	☐ 3	Sitting, inactive in a public place (example, a theater or a meeting)
☐ 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 circumstances permit
☐ 0	☐ 1	☐ 2	☐ 3	Sitting and talking to someone
☐ 0	☐ 1	☐ 2	☐ 3	Sitting quietly after lunch without alcohol
☐ 0	☐ 1	☐ 2	☐ 3	In a car, while stopped for a few minutes in traffic

Total score:_____

Social History & Habits:

Smoking: ☐ Current smoker ☐ Old smoker ☐ Never smoked

Cigarettes smoked per day: _____ Other tobacco products:_____

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Alcohol: ☐ Yes ☐ No Alcohol drinks per day:_____Alcohol type:_____

Coffee: ☐ Yes ☐ No Cups of coffee per day:_____

Glasses of caffeinated beverages or cola per day:_____

Marital status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with significant other
Occupation:_____ Working hours:_____

Past Medical History: Place an X if it applies to you.

Diabetes		Anemia	
High Blood Pressure		Peptic Ulcers	
Stroke		Acid Reflux	
Heart Disease or CHF		Kidney Disease	
Heart Attack		Thyroid Disease	
Angina		Arthritis	
Emphysema or COPD		Back Pain	
Asthma		Head Trauma	
Tuberculosis		Severe Headaches	
Other Lung Disease		Seizure	
Nasal Allergies		Fainting episodes	
Runny or Blocked Nose		Depression	
Hormonal Problem		Anxiety Disorder	
Urological Problem		Problems With Alcohol	
Prostate Problem		Problems With Drugs	

Other Medical Problems:_____

_____

Family History:

☐ Sleep Apnea ☐ Snoring ☐ Narcolepsy

Other medical problems in family members:_____

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Allergies: ☐ None

If present list your allergies:_____

_____

Home Medications List:

Medication name	Dose

Other Information:

_____
_____
_____
_____
_____
_____

Weight:_____ Height:_____ Neck size:_____

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Release of Information

We are more than happy to submit your claim to your insurance(s), who will return payment and/or explanation of benefits to our office. If there is any balance owed 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 scheduled clinic visit date, the patient may be responsible for all chargers not covered by their insurance provider.

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

Patient Name _____
(Printed)

Patient Signature _____

Date _____

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Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for Bel-Red Sleep Diagnostic Center, detailing how my information may be used and disclosed as permitted under federal and state law.

***A copy of the full notice of privacy practices can be obtained online through your patient portal or you can ask the front desk receptionist to provide you with one. ***

Name of Patient or Legal Guardian _____

Relationship (If applicable) _____

Signature of Patient of Legal Guardian _____

Date _____