BEL-RED SLEEP DIAGNOSTIC CENTER

PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Email: _____

Home Phone #: _____ Cell Phone #: _____

Is it okay to leave a detailed voicemail? ☐ Yes ☐ No Is it okay to send a text message? ☐ Yes ☐ No

Emergency Contact Name: _____

Emergency contact phone #: _____ Relationship: _____

Marital status: _____ Weight: _____ lbs. Height: _____ ft./in.

Occupation: _____ Working hours: _____

PRIMARY CARE PHYSICIAN INFORMATION:

Clinic Name: _____ Physician Name: _____

REFERRING PHYSICIAN INFORMATION: (Leave blank if same as your primary care physician)

Clinic Name: _____ Physician Name: _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

If someone other than patient is the insured party, please include insurers name and date of birth for claims

PRIMARY INSURANCE:

Plan Name: _____ Insured's Name: _____

Insured's Date of Birth: _____ Policy/ID #: _____ Group #: _____

SECONDARY INSURANCE:

Plan Name: _____ Insured's Name: _____

Insured's Date of Birth: _____ Policy/ID #: _____ Group #: _____

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What is the primary reason for your visit? _____

_____

Please help us understand the nature of your sleep difficulties. Check all that apply:

- ☐ Loud snoring
- ☐ Frequent awakenings at night
- ☐ Choking or gasping for air during sleep
- ☐ I have been told that I stop breathing while asleep
- ☐ I toss and turn at night and am a restless sleeper
- ☐ Still feeling tired even though I get a full night's sleep
- ☐ Crawling feeling in legs when trying to sleep
- ☐ Frequent cramps in my legs
- ☐ Trouble falling asleep or staying asleep at night
- ☐ Mind racing with thoughts when trying to sleep
- ☐ Fear of being unable to sleep
- ☐ Unable to fall back asleep after waking up during the night
- ☐ Lying in bed worrying when trying to sleep
- ☐ Waking up too early in the morning
- ☐ Sleep talking
- ☐ Sweating a lit at night
- ☐ Frequently using the bathroom during the night
- ☐ Teeth grinding while asleep
- ☐ Nightmares
- ☐ Morning headaches
- ☐ Morning dry mouth
- ☐ Sleep walking
- ☐ Sleep terrors
- ☐ Tongue biting while asleep
- ☐ 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
- ☐ Work shift interfering with sleep
- ☐ Pain interfering with sleep
- ☐ I often need to take sleep pills to fall asleep

SLEEP STUDIES AND CPAP USE (If applicable):

Have you ever had a sleep study? If yes, where and when? _____

Are you currently using a CPAP/BIPAP? ☐ Yes ☐ No

If yes, how often do you use a CPAP/BIPAP? _____ days per week _____ hours per night

If you are NOT using now, did you use a CPAP/BIPAP in the past? ☐ Yes ☐ No

If yes, how long did you use a PAP machine? _____ days/months/years (circle) _____ hours per night

What type of mask(s) did/do you use? ☐ Nasal ☐ Nasal pillows ☐ Full face

Did you or are you currently having trouble tolerating a CPAP/BIPAP? ☐ Yes ☐ No

If yes, why?

- ☐ Skin irriatation
- ☐ Leakage
- ☐ Mask too tight
- ☐ Dry Mouth
- ☐ Condensation in tube
- ☐ Machine too noisy
- ☐ Pressure seems excessive
- ☐ Can't exhale easily
- ☐ Air too cold
- ☐ Pressure seems too weak/not enough air
- ☐ Loose or uncomfortable headgear
- ☐

Other: _____

Current durable medical equipment (DME) company: _____

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SLEEP SCHEDULE

Please describe your typical sleep schedule:

During the *work week*, you go to bed at: _____, waking up at: _____

On days *off/weekends*, you go to bed at: _____, waking up at: _____

When do you usually feel at your best? ☐ Morning ☐ Evening

How long does it usually take you to fall asleep? _____ (Indicate minutes or hours)

How many times do you wake up during the night? _____

What causes to wake you up in the middle of the night? _____

How long are you usually awake when waking up at night? _____ (Indicate minutes or hours)

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

SLEEPINESS

Please indicate how likely you are to fall asleep in each situation:

	Never (0)	Rarely (1)	Frequent (2)	Always (3)
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g., theater, meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

SOCIAL HISTORY

Do you smoke cigarettes, or have you smoked in the past? ☐ Yes ☐ No

If Yes: How long have you smoked? _____ (Indicate years or months)

How much do you smoke each day? _____ (Indicate cigarettes or packs)

If you've quit, when did you stop? _____ (Indicate years or months)

Do you drink alcohol? ☐ Yes ☐ No If yes, how often do you drink? _____

Do you drink coffee? ☐ Yes ☐ No If yes, how many cups a day? _____

Do you drink other drinks with caffeine regularly? ☐ Yes ☐ No

(This includes tea, soda/pop, and energy drinks)

If yes, how many cups a day? _____

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MEDICAL HISTORY Please indicate if you have, or have had, any of the following conditions:

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

Please describe any other medical conditions or current physical complaint: _____

Please list all medications that you take: _____

Please list any allergies: _____

FAMILY HISTORY

Does anyone else in your family have sleep problems? ☐ Yes ☐ No

If yes, describe their relationship to you (e.g., mother, father, sister) and their condition (e.g., snoring, sleep apnea):

OTHER INFORMATION

Please describe any other information you feel may affect your sleep, or your treatment with us:

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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.

_____
Initial

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. *

_____
Initial

Patient Signature: _____ **Date:** _____

Parent or guardian name: _____

Parent or guardian signature: _____