COMPREHENSIVE SLEEP CENTER
Adult and Pediatric Sleep Medicine

PATIENT REGISTRATION FORM

PATIENT NAME LAST	FIRST	MIDDLE INITIAL		PATIENT DATE OF BIRTH
HOME ADDRESS	**APT. NO**	**CITY**	**STATE**	**ZIP CODE**
OCCUPATION • EMPLOYED • RETIRED • STUDENT	**SOCIAL SECURITY #**	**MARITAL STATUS** • S • M • D • W	**SEX** • M • F	**HOME PHONE** [ ] Preferred
EMPLOYER	**E – MAIL ADDRESS**			**WORK PHONE** [ ] Preferred
				CELL [ ] Preferred

RACE (check one)
• White • American Indian • Asian • Black or African American
• Native Hawaiian or other Pacific Islander • Other Race
• Decline to specify

ETHNICITY (check one) • Hispanic / Latino • Not Hispanic or Latino
• Unknown • Declined to specify

PREFERRED LANGUAGE: _____

PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN PHONE	REFERRING PHYSICIAN	REFERRING PHYSICIAN PHONE

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
PRIMARY INSURANCE		**SOCIAL SECURITY NUMBER OF SUBSCRIBER:**	
INSURANCE ID	**GROUP / CODE**	**EFFECTIVE DATE**	**POLICY HOLDER'S BIRTH DATE**
ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)			
CITY	**STATE**	**ZIP**	

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
SECONDARY INSURANCE		**SOCIAL SECURITY NUMBER OF SUBSCRIBER:**	
INSURANCE ID	**GROUP / CODE**	**EFFECTIVE DATE**	**POLICY HOLDER'S BIRTH DATE**
ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)			
CITY	**STATE**	**ZIP**	

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Location/Address: _____

3515 Coolidge Rd Ste A, East Lansing, MI 48832 Phone: 517-755-6888 Fax: 517-657-7759

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Pharmacy Phone Number: _____
Briefly describe your sleep problem(s) and why you have been referred to our clinic. _____
_____
How does the sleep issue(s) affect your life and daily activities? _____
_____
How did you become aware of the sleep issue(s)? _____
Have you ever been previously evaluated or treated for this sleep problem or any other issues with your sleep? Yes_____ No_____
If **YES**, please describe: _____
What is your usual BEDTIME? _____ AM / PM (weekday) _____ AM / PM (weekend)
What is your usual WAKETIME? _____ AM / PM (weekday) _____ AM / PM (weekend)
How long does it take for you to fall asleep? _____ Hours _____ Minutes
How many hours do you actually sleep at night? _____ Hours _____ Minutes
How many times do you awaken at night? _____ How long are you awake with each awakening? _____ Minutes
Do you nap during the day? Yes ___ No ___ If YES; How often? _____ How long are the naps? _____ hrs _____ mins
Do you have difficulty breathing at night? Yes___ No___
If **YES**, please describe: _____
Are you currently on CPAP/BiPap? Yes____ No____ If yes: pressure setting _____cmH2O
Current DME (Durable Medical Equipment Company) Name: _____

Have you ever used any medications, either prescription or non-prescription, to help initiate/maintain sleep? Yes No
If yes, please list below:

Name	Strength (MG)	Frequency	Were/are they effective?

	Yes	**No**	**Sometimes**
Do you have a regular bed partner?			
Does your bed partner complain you snore?			
Have you ever been told you have a pause in breathing while sleeping?			
Do you find yourself falling asleep when you do not mean to?			
When awakening in the morning do you awaken with a headache?			
When awakening in the morning do you awaken with a dry mouth?			
Do you usually feel tired during the day?			
Do you feel rested or refreshed after you sleep?			
Do you wake up too early and are unable to fall back asleep?			
Do you ever experience restlessness of the legs? (creepy crawling sensation or twitching)			
When falling asleep or trying to fall asleep do experience "restlessness of legs" when lying down before bed? **If YES, does this feeling get better with movement?**			

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When falling asleep or trying to fall asleep do you have thoughts racing through your mind? **If YES does this affect your sleep?**	Yes	No	Sometimes
Do you suffer from any kind of pain or discomfort when falling asleep or trying to fall asleep? **If YES, Where?**			
Do you ever feel down, depressed or hopeless? **If YES? How often?**			
When going to sleep or upon wakening do you ever feel paralyzed?			
Do you ever hear or see things that are not real when trying to fall asleep?			
ONLY when becoming emotional (laughing/anxious/nervous etc) have you ever had sudden muscle weakness such as jaw or head dropping, knee buckling, falling on the floor, difficulty talking, tingling for 1-2 minutes ?			

Check **ALL** which may frequently disturb your sleep:

○Heat/Cold
○Chest Pain
○Sweating
○Heartburn/GERD
○Choking
○Urination/How Often?__
○Muscle Cramps
○Snoring
○Leg Kicking
○Coughing
○Hunger/Thirst
○Wheezing
○Shortness of Breath
○Nasal Congestion
○Pain
○Gasping for Air

FAMILY HISTORY

Does anyone in your family have a sleep problem? If yes, please describe _____

_____

Heart Attack(who?) _____ Stroke(who?)_____ Diabetes(who?)_____

PAST MEDICAL HISTORY

Please indicate any conditions you have or have had in the past:

oHigh Blood Pressure
oDiabetes (I, II)
oStroke/TIA
oHeart Attack
oHeart Failure
oAtrial Fibrillation
○Hypercholesterolmia
oGERD/Heartburn
oAnxiety
oDepression
oCongested Nose
oCOPD/ Emphysema
oADD/ ADHD
○Fibromyalgia
oHead Trauma
oSeizure/ Epilepsy
oNerve/Muscle Disease
oParkinson's Disease
oThyroid Complications
oMuscle Cramps/Pain
○CAD

Others not listed above: _____

_____

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Have you ever had any previous Ear, Nose and Throat Surgeries? Yes____ No____ If **YES**, **Date Removed.**

- ○Tonsils _____
- ○Adenoids_____
- ○Nasal Septum/ Polyps removed_____

SOCIAL HISTORY

- Marital Status: □Single □Married □ Divorced □Widowed
- Occupation: _____
- Are you a shift worker? _____
- What are your usual work hours?_____
- Are you a tobacco user? Yes___ No____ What Type? _____ Previous Smoker?_____
- How often daily? _____ How Long? _____
- Do you use street drugs? Yes____ No____ Type_____ Frequency_____
- Any caffeinated beverages? (soda, coffee, tea) _____cups typical day_____ cups before bed
- Alcoholic beverages? (beer, wine, etc.) _____cups typical day _____ cups before bed

MEDICATIONS

Please list the name, dosage and frequency of current medications.

NAME	DOSAGE	FREQUENCY

Do you have any know **DRUG ALLERGIES**? Yes___ No___ If **YES**, **Please indicate the drug, reaction**.

_____

_____

Office Policy Information Sheet

Name of Patient: _____ Date: _____

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PLEASE NOTE: All charges and/or fees are due at the time of service. Please present your insurance card(s) and ID to the office staff with this completed form. We will copy them for your records and return them to you immediately.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Comprehensive Sleep Center for any services furnished to me by that physician. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

FINANCIAL & INSURANCE POLICY: We will be happy to bill your insurance carrier for you. If your insurance requires a referral to a specialist, it is **required** that you have your referral with you **at the time of service.** It is your responsibility to ensure that your referral is current. Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and payment is due upon receipt of that statement.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

Minor Patients: For all services rendered to minor patients, the adult listed as responsible party is responsible for payment.

Cancelation: We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a $50 charge for Clinic appointments and $175 for any Sleep Study appointment.

RETURNED CHECKS: It is our office policy to charge a fee of **$35.00** for any returned checks.

COMPLETION OF PRINTED MEDICAL RECORD FORMS: We will be happy to complete attending physician's statement, insurance and disability forms for our patients. The patient is responsible for payment of **$15.00** for any record request exceeding 25 pages. Please allow 14 business days for completion of forms.

DECLARATION: **I have read and I understand the financial policy of the practice, and I agree to be bound by these terms.**

_____ _____
Printed Name of Patient / Responsible Party DATE

_____ _____
Signature of Patient / Responsible Party DATE

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